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Ethics in Family Medicine: Faculty Handbook

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Ethics

Table of Contents

Ethics in Family Medicine:.....	1
Faculty Handbook.....	1
Table of Contents.....	1
Introduction.....	2
Preface.....	4
History.....	5
Acknowledgments.....	6
Competencies in Ethics and Professionalism for Canadian Family Medicine Residency Programs.....	7
Ethics Primer.....	11
Sample Lesson Template.....	21
Sample Lesson Plan 1.....	28
Sample Lesson Plan 2.....	37
Sample Lesson Plan 3.....	58
Sample Lesson Plan 4.....	81
Sample Lesson Plan 5.....	108
Tips for Integrating Ethics in Clinic.....	136
Appendix 1: Competencies in Ethics and Professionalism for Canadian Family Medicine Residency Programs.....	137
Appendix 2: Mapping Ethical Values to CanMEDS-FM Roles.....	141

Introduction

The general topic “ethics in family medicine” has been taught to family medicine residents in a variety of ways by Canadian family physician faculty members. There has never been an identifiable “best approach” either for covering the academic content or for integrating ethics teaching into clinical medicine, but several approaches have been tried, often by the local ethics expert. Experimentation is undoubtedly ongoing. Many useful teaching resources are now available, including some developed by members of the Committee on Ethics of the College of Family Physicians of Canada (CE-CFPC) and available at <http://cfpc.ca/Ethics>.

Feedback from Canadian teachers has prompted the CE-CFPC to develop a practical guide we offer here as the *Faculty Handbook*. It begins by outlining competencies for ethics and professionalism in Canadian family medicine residency programs, a section that will be repeated as an appendix to the handbook for easy reference. It also includes an ethics primer for ethics teachers and a suggested ethics case analysis method. The latter is presented as a sample lesson template. This analytical approach is an example of one that might be used by ethics teachers when discussing ethics cases with residents in more formal education sessions, such as academic half-days. Finally, there is a series of sample lesson plans highlighting topics of ethical interest in family medicine. The CE-CFPC hopes to expand this section of the resource in future online revisions of the handbook.

No single teaching methodology will fit well for all teachers in all settings. Local adaptations are encouraged and supported, ideally with feedback and suggestions provided on an ongoing basis to the CE-CFPC so that good ideas can be broadly shared through distributed materials such as this handbook, at national conferences, or in web-based resources.

The CE-CFPC will share some suggestions on integrating ethics teaching into regular clinical medicine teaching (ie, “bedside teaching”) but the main purpose of this handbook is to provide faculty with a hands-on, how-to approach for structuring and offering routine small-group semi-formalized instruction in family medicine ethics, identifiable as such for accreditation purposes. As mentioned earlier, the handbook begins with a set of competencies in ethics and professionalism. These competencies will be useful to program directors who wish to

review or confirm where ethics learning occurs in other areas of training, in addition to those more easily identifiable, formal ethics instructional sessions.

Ideally, all Canadian family physicians who are members of faculty should attempt to consciously link small-group discussion points to subsequent clinical encounters as relevant scenarios arise. For this to happen, **we recommend that most faculty members in academic departments or teaching units take part in structured ethics teaching** rather than leaving this task to locally identified ethics experts.

This recommendation has three important implications. First, it addresses practical concerns about the lack of availability of local ethics experts, especially at small or remote teaching sites. Second, it helps to remove the mystery that has long been associated with ethics teaching by offering practical tools and a structured approach to teaching ethics. Third, and perhaps most important, it helps to reinforce the message to residents that ethics is integral to the routine practice of clinical medicine and something that all family physician faculty members care about and support in the professional development of resident learners.

The proposed teaching format is for small-group sessions (eg, five to 10 residents), but with some minor changes it could also be adapted for somewhat larger groups (eg, 15 to 25 residents). The suggested lesson plans have been developed for one-hour sessions. Longer sessions are easily accommodated by the selection of additional topics from the topics listed under the headings “Values” and “Themes” in the reference document *Mapping Ethical Values to CanMEDS-FM Roles* (Appendix 2), which is based on CanMEDS–family medicine^{*†} (CanMEDS-FM) roles or topics of current or local interest to particular resident groups.

Although distance learning (eg, videoconferencing, webinars) has been used with some success, ethics discussions tend to have a lot of back-and-forth exchange, emotional or nuanced comments, and plenty of body language, none of which lend themselves well to certain electronic formats.

^{*}The CanMEDS-family medicine framework was adapted from: Frank, JR, ed. The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2005 [cited 2009 Dec 14]. Available from: <http://rcpsc.medical.org/canmeds/index.php>.

[†]Working Group on Curriculum Review. CanMEDS–family medicine. Mississauga, ON: College of Family Physicians of Canada; 2009. Available from:

<http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf>. Accessed 2012 Aug 17.

- Residency program directors might wish to review *Mapping Ethical Values to CanMEDS-FM Roles* (Appendix 2) in more detail. This document illustrates that family medicine ethics values are integral to CanMEDS-FM roles and could assist in the development of specific curricular components and evaluation strategies for all clinical domains within family medicine training.

A Note on Ethics Assessment

A working group of the Committee on Ethics is currently developing an ethics assessment toolkit/guide for family medicine teachers wishing to assess ethics and professionalism competencies. This guide, which will include practical clinical scenarios accompanied by observable, assessable behaviours or actions, will be presented at a later date as an additional appendix to this online faculty handbook. Future feedback from program directors and teachers in academic family medicine units regarding the usefulness and practicality of the assessment tools will be welcomed.

Preface

Ethics in family medicine: Faculty Handbook serves as a common reference for developing or reviewing curricula for teaching ethics and professionalism, and for training new faculty members teaching ethics. This handbook consists of several parts: ethics and professionalism competencies, an ethics primer, sample lesson templates, sample teaching modules called lesson plans, and tips for applying ethics in the clinic.

The competencies outlined beginning on page 7 of this handbook and repeated in Appendix 1 are meant to address ethical questions and concerns that arise in several clinical areas in family medicine, such as reproductive care and sexuality; maternal care; care of children; care of patients with distressed behaviours; care of patients with developmental disabilities, cognitive impairments, or mental health disorders; care of the elderly; palliative and end-of-life care; and the care of patients in specific settings such as emergency departments, hospitals, or long-term care facilities.

The topic areas identified as values and themes in *Mapping Ethical Values to CanMEDS-FM Roles* (Appendix 2) can be taught in various contexts (eg, clinical teaching, small-group discussion, or large-group didactic teaching) and evaluated by a range of methods as determined by each program (direct observations, case discussions, simulated patient exercises, written exercises, resident journals, etc.). The competencies can also be used by program directors for developing strategies for evaluating residents until the ethics assessment toolkit is developed.

The CE-CFPC has developed additional online resources including ethics cases, bibliographies, and references. Much of this material is currently available on the CFPC's website: <http://cfpc.ca/Ethics>.

History

The CE-CFPC has contributed to ethics curriculum development for family medicine residents and provided ethics teaching resources since 1990. In 2006, the CE-CFPC began a review of the resources available through the College's website for teaching ethics. At the 2007 Family Medicine Forum (FMF), participants at a CE-CFPC workshop directed to faculty members teaching ethics in family medicine residency programs identified as pressing concerns the ongoing need to train new faculty members in ethics and to maintain continuity and consistency within ethics programs. In evaluating the workshop, participants urged greater collaboration among programs in developing ethics curricula and other resources. They supported the CE-CFPC continuing to present workshops on ethics at FMF to highlight ethical issues in evolving areas and contexts in family medicine.

The mandate of the CE-CFPC was to formulate goals for a family medicine ethics curriculum and to compile resources that could assist program directors and faculty members teaching ethics in Canadian family medicine residency programs to develop or review their own ethics curricula. In 2009, the CE-CFPC devised curriculum goals. Members of the CE-CFPC who contributed to developing these goals represent several family medicine residency programs across Canada. Expert reviewers also contributed.

A draft of the curriculum goals was presented at FMF 2009 and was subsequently revised based on feedback. A decision was then made to produce a faculty handbook. This handbook now

contains a version of the often-revised goals, rewritten as *Competencies in Ethics and Professionalism for Canadian Family Medicine Residency Programs* (Appendix 1).

The CE-CFPC is aware that there are concurrent efforts within the CFPC to develop a competency-based curriculum for professionalism.[†] The topics of ethics and professionalism are intertwined. This handbook does not deal with all areas of professionalism but only with those that have significant overlap with ethics.

Acknowledgments

The CE-CFPC's lead author for the curriculum goals was Bill Sullivan, and for the Ethics Primer, Michael Yeo, along with input from William Sullivan. Keith Ogle edited both these documents, rewrote the curriculum goals as competencies, and contributed the remaining portions of this faculty handbook.

[†]For more information see Working Group on the Certification Process. *Defining Competence for the Purposes of Certification by the College of Family Physicians of Canada: The Evaluation Objectives in Family Medicine*. Mississauga, ON: College of Family Physicians of Canada; 2010. Available from: www.cfpc.ca/uploadedFiles/Education/Certification_in_Family_Medicine_Examination/Definition%20of%20Competence%20Complete%20Document%20with%20skills%20and%20phases.pdf. Accessed 2012 Oct 12.

Competencies in Ethics and Professionalism for Canadian Family Medicine Residency Programs

Curricula on ethics in Canadian family practice residency programs should relate residents' education in ethics to issues that arise specifically in family medicine. Graduates of a Canadian family medicine residency program should achieve the four competencies outlined below. Each competency is described in some detail, and examples are provided. *These lists are not intended to prescribe curriculum content, but are provided as examples only.*

A. Identify, Explain, and Apply Ethical Values and Principles Relevant to Family Medicine

1. Residents will be able to identify, explain, and demonstrate in their clinical attitudes and behaviours, the unwavering commitment to patients that lies at the heart of family medicine.
2. Residents will be able to describe and apply key ethical values and principles in patient- and family-focused care and discuss with their preceptors which particular values and principles are at stake in specific clinical cases. Examples of key ethical values and principles include the following:
 - Trust in the doctor-patient relationship
 - Respect for the patient's role in decision making (autonomy)
 - Privacy and confidentiality
 - Effacement of physician self-interest
 - Benevolence
 - Compassion
 - Honesty
 - Justice
 - Accountability
 - Prudence and stewardship
 - Consequences, duties, and obligations
3. Residents will be able to integrate the ethical values and principles of patients, family members, and other care providers into patient care by soliciting the views of these individuals attentively and respectfully. Residents will demonstrate that they are able to communicate with patients and family members in a manner that is caring; empathetic; and attuned to cultural, ethnic, gender and other diversities.

4. Residents will be able to identify, explain, and apply key ethical values and principles relating to other areas of family medicine such as practice management and relationships with third parties. Residents will be able to discuss particular values and principles at stake in these various relationships. Examples of common relationships include those with the following:
 - Pharmaceutical companies
 - Insurance agencies
 - Government and community service agencies
 - Colleagues and professionals in other disciplines
 - Health system resource allocators
 - Researchers
5. Residents will be able to describe how various values and principles can sometimes be in tension or conflict, both for family physicians and for their patients, and to manage these tensions and conflicts appropriately. For example:
 - Respecting a patient's autonomy might conflict with benevolence (eg, preventing harm)
 - Promoting trust in the physician-patient relationship and maintaining patient confidentiality might conflict with honesty and accountability
 - Benevolence in caring for individual patients might conflict with stewardship and justice (eg, failure to fulfill obligations to other patients)
6. Residents will be able to describe the importance of ethical concepts relevant to family medicine and apply them appropriately. Examples of ethical concepts central to family medicine include the following:
 - Patient- and family-focused care
 - Fiduciary relationships
 - Proportionality of interventional benefits to burdens

B. Define and Elaborate Ethical Responsibilities Pertaining to Professional and Legal Standards in Family Medicine

1. Residents will be able to access and outline professional responsibilities, standards, and policies that have a bearing on ethics in family medicine. Examples of applicable standards and policies include the following:
 - Codes of ethics
 - Canadian and provincial colleges of physicians and surgeons' (CPS') policies and bylaws
 - Licensing requirements

- Local institutional policies
2. Residents will be able to outline and describe how to find provincial and federal laws and regulations relevant to family medicine. Examples of relevant laws and regulations include those addressing the following:
 - Confidentiality and privacy
 - Consent to health care
 - Substitute decision making and advance directives
 - Involuntary admission to mental health facilities
 - Decision making regarding minors
 - Human rights and disability rights legislation
 - Communicable diseases
 - Abuse and neglect
 - Family law
 3. Residents will be able to outline the roles and responsibilities of family physicians, patients, family members, other care providers and consultants pertaining to professional and legal standards. They will be able to initiate and facilitate discussions with patients and preceptors pertaining to their ethical responsibilities relevant to these standards.

C. Demonstrate Ethical Reasoning

1. Residents will be able to demonstrate that they have taken into account the following components, if relevant, when analyzing specific cases:
 - Clinical facts and probabilities
 - Professional, legal, and ethical responsibilities
 - Ethical values and principles
 - Other applicable concepts in ethics
 - Approaches to ethical decision making
 - Views of the relevant stakeholders (eg, patient, family, other health care professionals, administrators)
2. Residents will be able to discuss and assess alternative courses of action, provide morally defensible reasons for decisions and actions with reference to the considerations named in C1, and apply their ethical reasoning.

D. Manage Ethical Disagreements and Seek Help Appropriately

1. Residents will demonstrate in their clinical interactions that they are able to identify and respectfully discuss and manage value differences and conflicts that arise in patient care and in working with others.
2. Residents will demonstrate an ability and willingness to seek clarification or advice in clinical situations involving complex ethical or legal dimensions or uncertainty regarding applicable ethical, policy, or legal norms.

Ethics Primer

A. Ethics in Family Medicine

1. Questions

- a) What are the values that inform family medicine and shape (or should shape) family physicians?
- b) How do these values come into play in daily practice?
- c) What is an ethical issue?

To answer these questions, it is helpful to distinguish the ethical dimension of family medicine:

- Daily decision making is informed by values such as trust in the doctor-patient relationship, respect for the patient's role in decision making, patient well-being, privacy and confidentiality, effacement of physician self-interest, benevolence, compassion and caring, intellectual honesty, justice, accountability, and prudence.
- These values are embedded in professional codes, law, and institutional policies, as well as in the individual consciences of physicians.
- Values are always present in the background of medical decisions and practices but not always made explicit or raised as issues needing discussion.
- Most of the time, the values at play in decision making and actions are not in tension or conflict (ie, the "right thing to do" is obvious or not in doubt).
- Even when the right thing to do is not in doubt, it might nonetheless be something that is challenging or even unpleasant to do.

2. Ethical issues that arise in family medicine

- With respect to some decisions, there might be ethical uncertainty about what to do ("What is the right thing to do?") when one must choose from among possible alternatives or courses of action. This uncertainty might be signaled by a feeling of unease, discomfort, or worry.

- This sort of uncertainty is not unusual or unexpected, and it mirrors similar uncertainties that arise on a daily basis with respect to the scientific side of medical decision making.
- Initially, alternative courses of action or decisions might not be clear, and some reasonable options might not have been considered yet; likewise, the values at stake might not be clear.
- The key thing about ethical issues is that they require conscious effort to address; they must be worked on or thought through. Some kind of analysis or deliberation is necessary.
- On such analysis, the “right thing to do” might become apparent: one course of action or decision might seem to be better than other possible and available alternatives, or the values promoted by that action or decision might be more weighty or important than the values that would be promoted by the alternatives.
- Sometimes, on analysis, two or more possible courses of action or decisions, and the values that recommend them, might seem more or less equally weighted. In such cases, and particularly when both courses of action are grim or suboptimal, the ethical issue involves a dilemma.

3. Take-home message

The practice of medicine includes the art of ethical deliberation. Values are pervasive in the practice of medicine. For example, physicians practice according to the ethical codes of the profession. Most of the time, these values are not at issue or in conflict. However, sometimes ethical issues arise from conflicting or competing ethical values and principles. To address such ethical issues responsibly, it is necessary to reflect and deliberate on them, taking into consideration the views of those who have a stake in living with the decision.

B. Challenges of Ethical Analysis/Formulation

1. Questions

- a) How does one recognize that one is faced with an ethical issue?
- b) How does one address or analyze an ethical issue?
- c) How can one facilitate ethical decision making?

a) **How does one know when one is faced with an ethical issue?**

In some cases, it is obvious that one is dealing with an ethical issue. Sometimes the values that are in tension are clear from the outset. At other times, the values in tension might not be clear at the outset but the physician experiences a sense of discomfort or unease, which signals the need for ethical analysis. Occasionally, a physician might not experience unease or discomfort at all when faced with an ethical issue, even though perhaps he or she *should* feel uneasy. For example, a physician might be oblivious to an ethical issue, or fail to recognize the situation as an ethical issue.

Reasons for not noticing ethical issues in medicine include the following:

- Conflating law or policy and ethics
 - Law and institutional policies provide guidance for ethical action. In many cases, the law or an institutional policy clearly requires that one perform one particular action rather than another. However, the right thing to do from a legal perspective is not necessarily the same as the *ethically* right thing to do. The guidance of law and of institutional policy is of great importance, but the law by itself does not and cannot resolve an ethical issue, even if the ethically appropriate thing to do is exactly what the law or institutional policy has as its main intent.
- Conflating clinical judgments and ethical judgments
 - Clinical judgment is about using medical knowledge and expertise to arrive at a decision that is medically best for the patient. Clinical judgment is already permeated by the value that is sometimes called “beneficence” or simply the commitment to do what is best for the patient. However, there are other values

that might be relevant besides a patient's medical well-being and these might be obscured by the guise of a clinical judgment.

- Lack of sensitivity to one or more values at issue
 - In some cases a physician might not be sensitive to a value that is at issue in a given situation. This might occur if the physician simply does not care about that particular value. More commonly, this occurs because the physician is too busy to notice the value at issue or is distracted by other concerns.

b) How does one address or analyze an ethical issue?

There is no simple, universally-agreed-upon procedure or method for analyzing ethical issues. Similarly, there is no universal agreement regarding which ethical theories should guide such analyses. Generally, however, there is broad agreement that one takes care to do the following:

- Collect the relevant clinical facts and probabilities, as far as these can be ascertained
- Consider relevant professional responsibilities, policies, laws, and legal requirements
- Identify those who have a stake in the ethical issue (eg, patient, family, most responsible physician, other health care professionals, administrators) and consider what part, if any, they should play in the process of coming to a decision
- Be as careful and exhaustive as possible in considering alternative courses of action
- Identify the ethical values and principles underlying any disagreements regarding these alternatives
- Apply relevant ethical concepts and approaches to ethical decision making that support these alternatives, which implies taking the time to think things through
- Look back at the outcomes of troubling decisions

Judging the clinical facts usually occurs within the province of the physician or medical team. Judging ethical values and principles, however, involves collaboration between the patient or designated decision maker (in determining what is good for the patient) and the physician (in determining professional responsibilities and what is acceptable to his or her conscience). It might also involve collaborating with other members of the health care team

or representatives of the health organization. Such distinctions between roles and responsibilities in ethical decision making are sometimes difficult and contentious.

c) How can one facilitate ethical decision making?

The goal of analyzing an ethical issue is to arrive at a morally defensible judgment and decision. Even after identifying the different values and theoretical approaches that underlie disagreements by those who have a role in deciding the issue, such disagreements might still persist. Following a process of analysis with care, such as the one outlined above and more completely described in the Sample Lesson Template section will increase the likelihood of an ethically defensible judgment and decision, which might be all that one can hope for when there is ethical controversy. Other considerations might include the following:

- Being willing, when asked, to provide an account of one's reasoning in support of the alternatives viewed as right and good
- Being clear about which course of action one would find morally problematic to participate in because of professional responsibilities and conscience, which might mean considering options for the transfer of the patient's care, if necessary
- Asking others (eg, ethics consultant or pastoral care provider) to provide input
- Proposing a process for reaching an acceptable decision

2. Take-home message

For a variety of reasons, a physician might not recognize that he or she is dealing with an ethical issue. There is no simple solution to this problem: the best one can do is to make an effort to avoid conflating law or policy with clinical and ethical judgments, and to be sensitive to the values that are part of the practice of family medicine.

When one is facing an ethical issue, some kind of analysis will be necessary to arrive at a responsible judgment and decision. There is no cut-and-dry formula for achieving such a judgment and decision, but it should at least include ensuring that the considerations listed above are taken into account. Sometime after the decision is made, the final step is very important; this is how we develop ethical maturity. Following such a process with care will increase the likelihood of arriving at an ethically defensible judgment and decision, which sometimes is all that one can hope for when there is ethical controversy.

C. Some Basic Ethical Terms and Distinctions

Terminology in ethics can be confusing. The meaning of key ethical terms is sometimes hard to pin down. Definitions are sometimes a matter of disagreement. Sometimes the same term is used in different senses by different people. The following analysis of key terms and definitions, although not comprehensive, could be helpful.

1. Values, moral values, principles, and virtues

The terms *value*, *principle*, and *virtue* have overlapping meanings. In ethical discussions they operate in much the same way, and in a sense, are simply different ways of talking about the same sorts of things.

The term *value* refers to something that is desired, prized, or otherwise believed to be worthwhile and to have importance. Although there might be different values, they can generally be grouped into four categories:

- Physical or material well-being
- Achievement or independence
- Relationships or the good of one's community
- Universal or spiritual goals (pursuing beauty, justice, truth, love, etc.)

Just about everyone desires one or more of these types of values and each person normally has some scale that orders the relative priority of these types of values, which informs his or her decisions.

Normative ethical theories specify some types of values as *moral values*, which means that a certain obligatoriness or "oughtness" attaches to them. For example, even if someone does not value fairness, or honesty, or the privacy of others, etc. in promoting good relationships and social well-being, one might say that he or she *ought* to uphold these values, and that he or she is ethically blameworthy for not doing so.

Principles give expression to values, but operate more directly as rules for behaviour or decisions, or as action guides. To invoke the principle of autonomy is to say that in one's dealings

with others one *ought* to be guided by respect for their autonomy. This amounts to much the same thing as saying that autonomy is an ethical value.

The term *virtue* refers to a character trait, naming a quality that is thought to be ethically desirable—one that persons might or might not have. For example, consistently respecting the autonomy of others is a virtue. But to invoke this virtue comes down to much the same thing as invoking the *principle* of autonomy (one ought to respect the autonomy of others) or the *value* of autonomy (autonomy is important or prized or cherished as promoting achievement or independence).

To be sure, these three ways of speaking—the language of values, the language of principles, and the language of virtues—are subtly different. Nonetheless, in moral discussion and analysis, they operate in much the same way: they pick out, name, or identify considerations which, ethically speaking, matter. Typically, ethical disagreement is a disagreement about the relative weight of competing values (or principles or virtues) relevant to whatever issue is being considered.

2. Factual judgments and value judgments

Factual judgments are judgments about what is empirically true, as a matter of fact. One is correct about the facts or one is not, and whether one is correct or not will depend on observable, measureable, or otherwise knowable things about the world, regardless of how one would like the world to be or how one thinks the world ought to be. Generally speaking, a diagnosis, a prognosis, a claim about what someone said or did not say, or what the law requires or does not require are judgments that admit of being either true or false, and that in principle, can be proven to be true or false by investigation or by the unfolding of events.

Value judgments, by contrast, always involve some notion of what *ought* to be. In this respect, they are not about what is true or false but rather about what is ethically right or wrong or ethically good or bad. This being the case, they cannot be proven or disproven. To say that someone lied is to make a *factual judgment*, but to say that someone should not have lied is to make a *value judgment*. To say that the law requires breaching patient confidentiality in certain instances is to make a factual judgment, but to say that the law ought to require breaching

patient confidentiality in certain cases (whether in fact it does so or not) is to make a value judgment.

Value judgments are often collapsed into or obscured by factual judgments, such that the value judgment is suppressed or hidden. Here are two examples:

- In ethical discussion, someone might make a claim about what the law requires or does not require as if, by itself, this resolves the ethical issue. What the person claims about what the law says could be true or it could be false as a matter of fact. In any case, the fact does not resolve the ethical issue about what ought to be done, unless it is taken for granted or assumed that one ought to always do what the law says, which, of course, is a value judgment.
- In a case where there is some question about whether to offer a patient a certain diagnostic or therapeutic option, someone might say that the option is not “clinically indicated” or is “futile,” as if this judgment were nothing but a statement of the clinical facts, and as if the clinical facts by themselves were enough to resolve the ethical issue. However, in analyzing the basis for the judgment carefully, we might find that it also contains a value judgment that is not being made explicit, such as, “the potential benefit to the patient is not worth the financial expenditure for the systems” or, “the risk of the treatment is not worth the potential benefit for this patient.” These sorts of judgments are value judgments that are disguised as or confused with statements of clinical fact.

The matter is much more complex than is conveyed in this analysis and the preceding examples. The key point is that judgments of facts and judgments of value are distinct, and they require different sorts of justification. Nonetheless, they are often run together such that value judgments are mistakenly collapsed into judgments about facts.

Separating and keeping distinct these two sorts of judgments is one of the main challenges of ethical deliberation and analysis.

D. Ethical Conventions and Ethical Theories

Ethical conventions are commonly held beliefs about what is right or wrong, or good or bad. Such conventions could vary a considerable amount from one society to another, and within a society

from one sub-group to another. *Ethical relativism* is the belief that ethics reduces to conventional beliefs and that there is no standpoint from which to assess the rightness or wrongness of conventional beliefs or to decide whether some conventional beliefs are ethically better than others.

Ethical theories are systematic investigations into questions of right and wrong and good or bad, which typically attempt to ground value judgments in a few or even one overarching principle. Recall that principles function as action guides or rules for behaviour, so ethical theories are commonly *normative* theories that lay the foundation for prescribing what *ought* to be done in certain circumstances.

For example, *utilitarianism* is an ethical theory that conceives good as *happiness* and prescribes that decisions and actions should produce the consequence that results in the greatest good (happiness) for the greatest number. By contrast, *deontology* is an ethical theory that is based not on promoting good consequences, but on carrying out an always-binding ethical duty or obligation.

Other ethical theories include virtue ethics (which focuses on promoting good character), discourse ethics, feminist ethics, and divine command theory.

E. The Ends of Health Care and Norms Regarding Therapies

Health care and medicine aim to help human beings thrive. Medicine does this in very particular ways, through avoiding, removing, or overcoming barriers that illness and injury present for human well-being or by providing comfort to patients, as in palliative care. Medicine seeks to optimize opportunity for all humans, irrespective of their unique and individual starting points.

Given these goals, medicine has developed various norms to guide the practical and prudent use of medical interventions or therapeutic efforts. Norms such as restoration, proportionality, parsimony, discretion, and totality might not be commonly named but nevertheless shape physician considerations regarding the appropriate uses and limitations of therapies.

Restoration posits that the goal of the intervention should be to restore to the patient functionality, comfort, and a sense of harmony, as much as possible under the circumstances.

Proportionality means both that the intervention should be appropriate to the goal sought and that its benefits should be proportionate to its risks and burdens to the patient. An intervention might be regarded as disproportionate if its risks and burdens outweigh a reasonable hope of achieving the intended benefits (ie, the goals of care to which the patient and physician are committed). For example, in a 93-year-old patient with metastatic breast cancer, chemotherapy followed by radiotherapy might be considered disproportionately burdensome if the expected survival benefit was thought to be approximately six months.

The proportionate/disproportionate distinction involves the health care provider's assessment of possible therapeutic options (including non-treatment) based on some weighing of medical benefits and burdens for patients with similar health conditions. This distinction seeks to set reasonable limits on therapeutic means that health care providers should propose or support.

Medical professionals often compare and rank several therapeutic options according to their relative benefits and burdens for a given patient group; these are defined collectively by a diagnosis and prognosis and guided by consideration of the outcomes of health care, standards of the profession, and goals and aspirations of the patient.

Health care providers are obligated to propose only medically proportionate interventions that are consistent with the ethical norms of health care, the standards of the profession, and the goals and aspirations of the patient. They need not offer or support disproportionate ones.

Parsimony means that one should use only as much of an intervention as is necessary to achieve the intended goal. Simple examples include using the minimal efficacious dose when prescribing medication or the lowest effective radiation dose when treating malignancies.

Discretion is a norm that reminds physicians to be respectful of the limits of medicine. For example, in the context of caring for those facing imminent death, providing patient comfort rather than aggressive therapeutic interventions could be formulated in terms of the norm of therapeutic discretion.

Totality refers to the principle that the overall well-being of the patient takes precedence over specific parts or functions. For example, surgical removal of a cancerous kidney can be justified ethically according to this norm.

Sample Lesson Template

A. Overview

Ethics education sessions with family medicine residents should remain flexible in terms of format. The suggestions provided in the following lesson template are simply ideas from which faculty may pick and choose. While specific topics in ethics are typically associated with standard sets of values and discrete background content, actual discussions with residents will vary in format and tone, according to the residents' interests, life contexts, cultural and ethnic backgrounds, and stages of clinical experience. In other words, ethics discussions can get very messy. Fortunately, they are rarely dull.

Ethics teaching can also be done more formally or didactically than we do in this format, in which we assume the use of clinical case discussion. It is important to understand that while the template described below appears to be a stepwise, linear progression, clinical scenarios are typically much more complex and disorderly. Additionally, human beings tend to think in a non-linear fashion, frequently returning to previous steps along the way, altering opinions on the basis of new facts, and adjusting arguments on the basis of new and persuasive evidence. Therefore, the sequence shown here would be more accurately displayed as containing a series of feedback loops, with each step undertaken influencing both subsequent and preceding ones. Facilitators are encouraged to “go with the flow” when the discussion seems productive, rather than adhering rigidly to the format outlined below.

B. Lesson Template

Typically, the following areas will be touched on by family medicine faculty involved in teaching ethics.

1. Introduce the topic

- a) The instructor might choose to briefly present a case from his or her own experience, either real or composite, that involves the topic areas to be discussed in the session. (Cases can also be chosen from the Sample Lesson Plans section of this handbook.)

- b) The purpose of the brief case presentation is to highlight the clinical relevance of the ethics issue, helping the residents to understand its real-life importance as a component of everyday clinical medicine.
- c) The instructor should stop short of telling what happened near the end of the case presentation, reserving these details for the last step in the process.
- d) After listening to or presenting the case, the instructor has the option of asking the residents to identify the main ethics topics that seem to arise within the described case. If several relevant topics are identified, the instructor might wish to narrow the scope of the discussion by suggesting a priority topic.
 - For example, the instructor might say, “This appears to be a case that involves the ideas of informed consent and substitute decision making.”
- e) Occasionally, the instructor might simply begin by *naming* the priority topic and then asking the resident group to provide a suitable (de-identified) case description from the residents’ own personal or clinical experience. Remind the residents to stop short of describing the case resolution.
 - Generally, resident-presented cases work better if the entire group has been made aware of the topic ahead of time. It can be useful for residents to briefly discuss their cases with the instructor prior to the session to gauge suitability.

Restate the topic:

- f) Regardless of case presenter (faculty member or resident), following the case presentation, the instructor should *clearly restate the purpose of the session* by explicitly identifying the priority topics. The instructor should emphasize that the topic commonly (or perhaps only rarely) arises within the normal context of family medicine clinical practice.
- g) Instructors might wish to highlight the topic’s relevance in the context of the ethics competencies (Appendix 1). They might also wish to refer to the applicable values and themes as identified in the document *Mapping Ethics Values to CanMEDS-FM Roles* (Appendix 2).

- h) At this point, it is probably counterproductive to get into a discussion regarding solutions to the case, although many residents will already be formulating their own solutions.
- i) It is often useful to ask the residents for their initial ideas regarding the ethics problem. Typically, they will state the problem in terms of possible alternative courses of action, or *action alternatives*. Action alternatives form a natural beginning point to many case discussions in ethics, even though they ideally arise at a later point in formal case analysis.
- j) If the instructor chooses to have the residents suggest a few possible action alternatives, they should be encouraged to do so without detailing their supporting arguments. The instructor can state that the values underlying or supporting these proposed alternatives will be identified more clearly later on, along with an attempt to weigh and balance their relevance, applicability, and importance.

2. Review the facts of the case

- a) After the case has been presented, ask the residents whether there are other facts they would find useful. The person presenting the case might be able to supply some of these facts, while others will remain unknown. The instructor can offer to make up important missing facts if he or she anticipates that the case discussion will work better with this information available.
- b) A convenient and useful way to gather all the necessary facts is to organize them into groups using the bio-psycho-social format. This is not always necessary, but it might help to avoid large gaps in data gathering.
- c) Emphasize that some facts such as medical prognosis, and occasionally, diagnosis, cannot always be known with complete certainty, but that in real life, decision making must proceed, despite such uncertainty.
- d) In addition to medical facts, be sure to ask about psychological facts such as the patient's current state of mind and previously stated therapeutic goals. Relevant social facts would include family context, religious and cultural factors, social support systems, and relevant policies and laws.

3. Review professional responsibilities

- a) Ask the residents to explain any professional responsibilities, policies, laws, or regulations that might apply to the case.
- b) Ask whether any of these standards conflict.
- c) If a particular standard appears to bear directly on one of the action alternatives mentioned in parts 1 i) and 1 j), draw this to the residents' attention, as some action alternatives might be automatically ruled out.
- d) Provide residents with directions to access necessary resources (eg, *CMA Code of Ethics*) if they seem unaware of the case's relevant standards.

4. Identify relevant decision makers

- a) Ask for suggestions regarding the relevant decision makers.
- b) While many decisions involve only the patient and the most responsible physician (MRP), other people often feel they have a say in the case. This is especially true of family members.
- c) Explore issues of competency, partial competency, dementia, immaturity, fear, depression, or other factors that might affect both the legitimacy and capability of the relevant decision maker.
- d) Identify any possible conflicts of interest among the decision makers.
- e) Identify the rights, roles, and responsibilities of surrogate decision makers if applicable.
- f) While it is crucial to recognize family influences governing decision making, appropriate elements of confidentiality and informed consent must also be preserved.

5. Consider action alternatives

- a) Review any action alternatives already suggested; see 1 i) and 1 j).
- b) On the basis of discussion to this point, ask the residents whether new action alternatives have become apparent.

- c) Rule out or modify action alternatives that directly conflict with therapeutic goals as voiced by competent patients, and those that are illegal, impractical, against recognized policy, etc.
- d) Ask the residents to remain as open as possible to any available options—even those that might be viewed as “fringe,” non-medical, risky, unpopular, exotic, etc.
- e) To avoid polarizing the debate, try to resist the temptation to ask the residents to name the “right” or “ethical” alternative.

6. Identify values and principles supporting various alternatives

- a) Ask the residents to outline some of the values and principles they have in mind when they reflect on each action alternative.
- b) Advise residents that it sometimes helps to write these values down beside the proposed action alternatives.
- c) At this stage, try not to rank these values and principles. Instead, just recognize openly that most realistic courses of action are supported by legitimate and often deeply held values. This point will emphasize that ethics issues are ethically controversial primarily for that reason; they bring values into conflict or competition.

7. Weigh and balance various alternatives

- a) Ask the residents to develop arguments in support of one or more particular courses of action, as opposed to their alternatives. Small-group discussion can be useful at this stage.
- b) Remind the residents to apply their knowledge of ethical concepts and themes in family medicine, as well as the values they have identified underlying the various action alternatives.
- c) When weighing and balancing various alternatives and their supporting values, suggest to the residents that there is no mathematical calculus—more often than not, the balance is not heavily weighted in one direction.
- d) Residents might suggest that there is no right answer in ethics. Try to resist this relativity trap. Your response might include some of the following suggestions:

- In fact, there are often *several* “right” answers, insofar as several alternative courses of action can have strong ethical justification.
 - In ethical dilemmas, we are usually looking for the *best possible* solution rather than the *only right* solution.
 - Sometimes, there are several good choices, each having equally valid supporting arguments.
 - Sometimes, there are no good choices, but one still needs to choose. This is often referred to as the “lesser of many evils” scenario.
 - Sometimes, choosing to defer, to step back, or to temporize is the best possible alternative.
- e) Recognize the possibility of not coming up with a unanimously accepted solution. This happens relatively frequently—not everyone agrees at the end of the discussion, but all should agree that the reasons supporting the chosen course of action are valid, understandable, and fair.
- f) Occasionally, the discussion will get stuck, or will stall. This presents an opportunity to ask the residents what they would do next if such a situation were to arise in real life. Options could include consultation with an ethicist or ethics committee, conversation with other colleagues, review of the relevant literature, etc. Keep in mind that many ethics decisions in medicine are not emergent or urgent. Reflection takes time.

8. Review the outcomes

- a) Remind the residents that one of the luxuries of case discussions is that no real patients are harmed as a result of decisions made.
- b) In real life, patients are sometimes harmed, as are families and other parties to the process of medical decision making.
- c) If a “real” (but de-identified) case was presented, ask the resident who presented it to tell the group what really happened in the end. See how closely this resolution matches the preferred course of action as decided during the case discussion. Similarly, if the instructor presented the case, the ending can now be revealed.

- d) While the preferred action alternative is often, and perhaps preferentially, the one that remains the most consistent with the weightiest values and most persuasive principles and arguments, there is little doubt that actual outcomes do matter.
- e) Ask the residents to consider whether the actual outcome of the real case was, in retrospect, the best possible outcome, as viewed through the eyes of those involved. Was it accepted and valued by the patient, the MRP, and the family? Did it achieve mutually-agreed-on goals? Did it involve the least harm to values and principles that were sacrificed or compromised as a result of the decision? Would the participants make the same decision again in similar circumstances?
- f) Emphasize that in real life, looking back at outcomes is crucial. It is not so much a matter of learning from one's mistakes as it is developing an internal library of paradigm cases from which to draw applicable and useful parallels in future case analysis. In other words, we can all get better at this and become more ethically mature through mindful, intentional reflection on the outcomes of troubling cases.

Sample Lesson Plan 1

A. Deriving Family Medicine Values

Sample Lesson Plan 1 describes an introductory lesson that instructors might find useful as a way of beginning a series of ethics sessions. Such a series is often designed on a two-year rotating schedule, but it might be beneficial to repeat Lesson Plan 1 on a yearly basis, excusing the senior residents if they attended this session previously.

The purpose of this introductory lesson is to set the stage for the relevance of ethics in family medicine by involving the residents in deriving the relevant values on which subsequent lessons will build. Its format is somewhat different than that suggested in the Sample Lesson Template.

1. Introduce the topic

- a) This lesson can be introduced by saying that ethics education in family medicine residency is a required component of the residents' training. Formal curriculum competencies have been established. While curricula will vary from program to program, evaluation tools are expected to include criteria for establishing whether residents are meeting the expected competencies.
- b) Ethics teaching will be reviewed during periodic program accreditation visits. There will be an expectation that both formal and informal ethics education is occurring on a regular basis.
- c) Most important, ethics, morals, values, and principles are integral parts of everyday family medicine. Topics and issues discussed in these formal sessions will be revisited in the clinical context by all teaching faculty. The expectation is that residents will display evidence of knowledge of ethics content, while demonstrating ethical skills, attitudes, and behaviours.
- d) Provide residents with website information regarding the CFPC competencies for ethics and professionalism.

- e) State the following: “The *purpose of today’s session* is to help us understand how values that inform family medicine decisions and practices can be derived from carefully reflecting on basic human health care needs.”

2. Pose the question

- a) Ask, “*What do people care about or value when it comes to health care?*”
- b) Ask the residents to supply ideas gained from their own personal, family, or clinical experience.
- c) Do not attempt to rank or prioritize these ideas. Any stated wants or needs are important and many of them will end up being founded on similar supporting values.
- d) Encourage each resident to supply at least one idea and write down or display the ideas as they are proposed.
- e) Commonly expressed needs and wants will include the following:
 - Access to necessary services (community based, acute, long-term, etc.)
 - Timeliness of access and subsequent management
 - Good pain management
 - Empathy, compassion, and respect
 - Good communication with providers and a sense of being heard
 - Avoidance of suffering whenever possible
 - Affordability
 - Support at the end of life
 - Equity and fairness
 - Safety and best evidence
 - Patient participation in decision making and a sense of having options
 - Continuity of care, follow-through, and the keeping of promises
 - Maintenance and improvement of health
 - Competence and skill of health care providers
 - The desire for privacy and confidentiality

3. Ask for practical implications and associated issues

- a) Ask the residents to reflect on each of the wants and needs they proposed by naming some practical implications or issues that might arise in the context of that particular want or need.
- b) Some of the things they will propose can later be named as values or themes commonly recognized in family medicine ethics.
- c) The italicized points below following each want or need on the sample list will be referenced at the end of this lesson plan.

Access

- Geographic location of services (rural, inner city, reserves, northern, and remote)
- Transportation availability (walking, buses, weather variability, parking)
- Reasonably available and locally comprehensive services
- No unfair delay in access to experts, specialists, scarce resources:
 - *Wise use of health care resources*
 - *Avoidance of unjust discrimination*
 - *Continuity of care*
 - *Advocacy for vulnerable or marginalized patients and populations*
 - *Patient-centred care*

Timeliness

- Wait time for primary care
- Wait time for investigations
- Wait time to see a specialist
- Wait time for surgeries
- Wait time for other interventions (eg, chemotherapy)
- Wait time for long-term care, palliative care:
 - *Patient-centred care*
 - *Patient safety*

- *Collaboration and partnering*
- *The need to contribute to system improvement*

Pain management

- Discussion of good pain control versus eradication (ie, efficacy)
- Fear reduction, awareness of likely course (eg, Is it going to get worse?)
- Reduction of the number of medications and side effects (parsimony)
- Continuity of care with respect to pain management
- Adequate counseling and awareness of alternatives
- Self-management techniques and ease of use at home:
 - *Caring relationships*
 - *Patient-centred care*
 - *Empathy*
 - *Compassion*

Empathy, compassion, and respect

- Patient-centred care, primary consideration of patient well-being
- Provider awareness of patient context, including social and family relationships
- Nonjudgmental attitudes
- Respect for religious and cultural views
- Respect for social and cultural views regarding medical decision making:
 - *Protection of privacy and confidentiality*
 - *Empathy*
 - *Altruism*
 - *Respectful interactions*
 - *Compassion*
 - *Sensitivity*

Good communication and a sense of being heard

- Adequate, focused time spent with the provider
- Clear evidence of provider being willing to listen
- Explanations provided in plain language
- Translator provision as necessary
- Empathetic and relaxed communication style
- Patient's views sought and considered:
 - *Good communication*
 - *Reliability*
 - *Accountability*
 - *Maintenance of professional boundaries*

Avoidance of suffering

- Pain avoidance is only one aspect
- Physical, cognitive, emotional, social, and spiritual components
- Provider awareness of patient context and individual concepts of "harm"
- Clear discussion of predictable outcomes and means for reducing suffering
- Solidarity of purpose, goals (eg, consistent teamwork and messaging)
- Facilitation of access to support:
 - *Empathy*
 - *Compassion*
 - *Idealism*

Affordability

- Provider awareness of patient's financial circumstances
- Attention paid to cost of suggested therapies
- Awareness of associated health care costs (eg, transportation to appointments)
- Cost awareness of uninsured services

- *Idealism*
- *Honesty*
- *Compassion*

Support at the end of life

- Fear reduction through open communication
- Support arrangement for palliative services
- Support for dying at home, if desired
- De-medicalization of the dying process
- Excellent symptom control
- Shared understanding of palliative goals:
 - *Long-term commitment to patients*
 - *Compassion*
 - *Empathy*
 - *Respectful interactions*

Equity and fairness

- Linked closely to access issues
- Patients want fair, non-discriminatory treatment and resource allocation
- Requests for unfair prioritization need to be discussed openly
- Avoidance of using vulnerable patient status for political ends
- Access to interim support while on the waiting list
- Demonstrable recognition of good resource stewardship:
 - *Integrity*
 - *The need for professional attitudes*
 - *Respect for patient individuality and diversity*
 - *Recognition and management of conflicts of interest*

Safety and best evidence

- Patients need to be able to trust their providers and the system
- Increasing reliance on best evidence and best practices
- Safety protocol development (eg, adverse incident reporting)
- Quality measurement and selection of appropriate markers
- Open discussion of medical errors
- Information regarding research outcomes and benefit of participation:
 - *Principles of ethics in research*
 - *Responsibilities to the profession*
 - *The ethics of patient safety and medical error*

Patient participation in decision making

- Patients legitimately demand an active role in their own health care
- Respect for autonomy has become a fundamental principle of modern medicine
- Education around limitations to autonomy is necessary
- Many implications for substitute decision making, advance directives
- Issues of consent/refusal, coercion, privacy, confidentiality
- Implications for decisions made by minors
- Awareness of legal requirements, privacy policies:
 - *Protection of privacy and confidentiality*
 - *Patient-centred care*
 - *Respectful interactions*

Continuity of care:

- Continuity of care is a fundamental principle for family medicine
- Patients want to know their providers and to feel well-known by them
- Continuity is more time efficient
- Continuity is safer

- Continuity builds trusting relationships
- Strong therapeutic attachments exist between providers and patients:
 - *Continuity of care*
 - *The unique relationship between family physicians and their patients*
 - *Caring relationships*

Maintaining and improving health

- Patients want to feel supported in making healthy lifestyle choices
- Realistic goal setting
- Awareness and respect for alternative health management choices
- Affordable access to safe and evidence-based interventions and behaviours
- Need for physician knowledge and educational role
- Patients want to be partners in achieving their health care goals:
 - *Collaboration and partnering*
 - *The unique relationship between family physicians and their patients*

Competence and skill of health care providers

- Patients want to feel that they are in good hands
- Patients assume that their physicians have adequate medical training
- Patients assume that the system will protect them from incompetence
- Patients trust licensing bodies:
 - *The need for self-improvement*
 - *The need for clinical competence*
 - *Implications of the social contract*
 - *The need for professional attitudes*
 - *Maintenance of professional boundaries*

Privacy and confidentiality

- Patients want to know who is in their “circle of care” and what constitutes a breach of confidentiality
- Patients need to know when private information must be shared due to laws and regulations
- Patients need to know any privacy implications related to insurance claims
- Patients want to feel assured that inadvertent breaches of confidentiality will not occur (eg, elevator talk or cafeteria talk):
 - *The need for professional attitudes*
 - *Protection of privacy and confidentiality*
 - *Respectful interactions*
 - *Patient-centred care*
 - *Good communication*
 - *Integrity*
 - *Honesty*
 - *Continuity of care*

3. Reflect on the ethics values and themes and the residents’ underlying wants and needs

- a) Refer back to the list the residents made earlier (the one naming common health care wants and needs in 2 e)).
- b) Under each of these wants and needs, you will have written some of the practical implications and issues that arise from them.
- c) Based on the wants and needs listed, ask the residents to volunteer any *additional ethics values and themes* they might have missed.
- d) Circle all the words or phrases that match those listed in the appended reference document *Mapping Ethical Values to CanMEDS-FM Roles* (also italicized above).
- e) Congratulate the residents for deriving the same ethics values and themes that can be distilled from a foundational document governing their residency education (CanMEDS-FM).

Sample Lesson Plan 2

A. Advance Care Planning: Relevant CanMEDS Values and Themes

Values

- Patient-centred care
- Continuity of care
- Respectful interactions
- Collaboration and partnering
- Good communication
- Long-term commitment to patients

Themes

- The unique relationship family physicians have with their patients
- The ethics of team participation
- Respect for patient individuality and diversity
- Wise use of scarce health care resources
- Advocacy for the health and well-being of communities and individual patients and in particular, vulnerable or marginalized patients and populations

1. Introduce the topic

- a) Briefly present the following case. It can be electronically displayed or simply read aloud.

Case:

You are a family physician working in a community-based group practice. You and your partners frequently admit patients to hospital. Your patient, Mrs J, is an 83-year-old woman recently admitted after falling and fracturing her hip in the dining room of her senior's residence. She has been your patient for many years and you feel you know her fairly well.

Mrs J has a son (Max) and a daughter (Jennifer), both in their early 50s. Jennifer is married and lives with her family in another province. Max is divorced and single, and lives just a few blocks

from Mrs J's residence. He has been quite involved with her care recently, as Mrs J has become increasingly forgetful and now requires frequent reminders from residence staff regarding routine assisted daily living activities (ADLs). Fortunately, her meals, cleaning, and laundry have been provided at the senior's residence since she moved there after her husband's death three years ago.

About two years ago, Mrs J created an advance directive with your encouragement and assistance. She visited you in clinic to discuss these plans on at least two occasions, each time arriving with her daughter, who made the trip to visit Mrs J for that purpose. Although Max did not attend these visits, both Mrs J and Jennifer told you that he was aware of the directive's contents and was in agreement with everything mentioned. You have met both adult children on several occasions and consider them to be intelligent, caring, and responsible individuals.

Mrs J has now had a stroke while recovering from her hip operation in hospital. Her speech is no longer understandable and she cannot move her right arm and leg. You are her attending physician and you recognize that she will not be able to return to her senior's residence, as her hemiplegia is fairly dense. While she can still swallow, her interest in food has declined and she frequently chokes while eating, even when consuming a softened diet. She often pushes her plate aside when offered food. The hospital nutritionist has recommended that a PEG tube be placed and tube feeding initiated.

Jennifer strongly agrees with this suggestion but Max does not think his mother would want to be tube fed. Mrs J's advance directive does not address tube feeding specifically, but cautions against using any "artificial life-prolonging interventions" in the context of an "irreversible and life-threatening health condition."

Both Jennifer and Max have drawn you aside in the hospital corridor, seeking to persuade you to abide by their own views. Mrs J is unable to express her wishes, but does seem to be fully aware of her surroundings. You remain undecided regarding the feeding tube, but notice that Mrs J's nutritional status is greatly declining and that Max and Jennifer's usually close relationship appears to be somewhat strained. What should you do?

- b) Alternatively, present a case from your own experience, involving disagreements about advance directives. Stop short of telling them "what happened" while presenting the case, reserving these details for the last step of the analysis process.

- c) After presenting the case, ask the residents to identify the main ethics topics that seem to arise within the case:
- *The topic “advance directives” is likely to be suggested. You might say “I agree. This appears to be a case involving a dispute over the interpretation of an advance directive. But what additional ethics issues are likely to arise for the people involved?”*
 - *Sometimes, institutional policies and practices will introduce uncertainty, ambiguity, or tension that stems from the differences between a family physician’s ongoing continuity-of-care role and the specialist’s time-limited involvement.*
- d) The residents might suggest some of the following relevant issues listed below. It would be useful to write them down or display them for future reference:
- *Respect for autonomously stated wishes, as outlined in an advance directive*
 - *Decision making in the context of dementia*
 - *Substitute (proxy) decision making*
 - *Resolving disagreement in the family context*
 - *Resolving health care team disagreement*
 - *Appropriate end-of-life care*
 - *Compromised cognition and the assessment of capacity*
 - *Health care resource usage (ie, tube feeding, electrolyte monitoring, etc.)*
 - *Risk/benefit assessment*
- e) If the list of identified issues is long, you might need to narrow the scope of the discussion by suggesting a few priority topics along the lines of the purposes stated immediately below.
- f) *The main purposes of today’s case presentation:*
- *To highlight the clinical and ethical relevance of advance care planning*
 - *To understand that advance care planning is becoming much more common*
 - *To recognize that advance directives are increasingly favoured by patients and families as tools for discussing and documenting future health care plans*

- *To understand why family physicians are well situated to assist patients with advance care planning*
- *To understand an important role for family physicians when their patients are admitted to hospitals and other health care institutions*

Restate the topic:

- g) After outlining the case, you should clearly restate the purpose of the session by explicitly identifying the priority topics. You should re-emphasize that the topics commonly (or with some topics, only rarely) arise within the normal context of family medicine clinical practice.
- h) You might wish to highlight the topic's relevance in the context of the ethics curriculum competencies (Appendix 1). You might also wish to reference the applicable values and themes as identified in the document *Mapping Ethical Values to CanMEDS-FM Roles* (Appendix 2), some of which the residents will have already identified in step 1 d). A list of relevant values and themes is provided to instructors at the beginning of this lesson plan.
- i) At this point, it is probably counterproductive to get into a discussion regarding solutions to the case, although many residents will have already formed their own solutions.
- j) It is often useful to quiz the residents about their initial ideas regarding the ethical tensions by asking, "What is the problem in this case?" Typically, they will state the problem in terms of alternative possible courses of action, or *action alternatives*. Action alternatives form a natural beginning point to many case discussions in ethics, even though they ideally arise at a later point in formal case analysis. In this case, the most obvious action alternatives are as follows:
 - *The family physician could follow Jennifer's advice and ask for the tube to be inserted.*
 - OR
 - *The family physician could follow Max's advice and instead keep Mrs J as comfortable as possible without artificial feeding.*

- k) If you choose to have the residents suggest a few other possible action alternatives at this time, you should encourage them to do so without detailing their supporting arguments. You can state that the values underlying or supporting each of these proposed alternatives will be identified more clearly later on, along with an attempt to weigh and balance their relevance, applicability, and importance.

2. Review the facts of the case

- a) After the case has been presented, ask the residents whether there are other facts they would find useful. The person presenting the case might be able to supply some of these facts, while other facts will remain unknown. You can offer to make up important missing facts if you anticipate that the case discussion will work better with this information available.
- b) A convenient and useful way to gather all the necessary facts is to organize them into groups using a bio-psycho-social format. This is not always necessary, but it might help to avoid large gaps in data gathering.
- c) Emphasize that some facts such as medical prognosis and occasionally, diagnosis, cannot always be known with complete certainty, but that in real life, decision making must nevertheless proceed.
- d) In addition to biological facts, be sure to ask about psychological facts such as the patient's current state of mind and previously-stated therapeutic goals. Also ask about social facts, which might include family context, religious and cultural factors, social support systems, and relevant policies and laws.
- e) Facts that could prove useful for this particular case discussion might include the following:
- *Biological*
 - *Mrs J's diagnosis is quite certain, as verified by physical exam, CT scan of the brain, and neurologist consultation.*

- *Although Mrs J's prognosis is guarded in terms of longevity, it is fairly clear that she will not recover much use of her arm and leg, and she is not a suitable candidate for intense rehabilitation.*
- *It seems unlikely that Mrs J will recover her ability to speak or to swallow without difficulty.*
- *Mrs J's dementia was rated as mild to moderate prior to the stroke.*
- *Mrs J has no other serious health conditions apart from chronic hypertension.*
- *Mrs J's recovery from recent surgery has been uncomplicated, although it now appears she will never be able to test her new hip.*
- *Mrs J's renal status, although mildly compromised, is currently stable.*
- *Mrs J is losing weight each day, probably due to her inability to consume much food.*
- *Psychological*
 - *There is no evidence that Mrs J is depressed, or that she has been in the past.*
 - *Prior to her fall, Mrs J's cognition was compromised primarily due to significant memory deficits.*
 - *Mrs J worked as a secretary prior to her retirement 20 years ago.*
 - *A consultant psychiatrist has been unable to assess Mrs J's capacity for decision making due to the effects of her stroke.*
 - *At the time she created her advance directive, her family physician did not have any concerns about her cognition.*
 - *Mrs J has always had a straight forward and uncomplicated approach to life and decision making.*
 - *When you assessed her in the emergency department after her fall, Mrs J told you that on the farm, they usually had to shoot old horses like her when they had a broken leg.*

- *Social*
 - *Mrs J's son and daughter appear to be truly devoted and committed to acting in their mother's best interests.*
 - *Advance directives are well recognized legal entities in this province (All Canadian jurisdictions have some sort of legislation governing the use of advance directives in health care).*
 - *Mrs J has never mentioned being particularly religious and her son has responded "non-denominational" on her hospital admission form.*
 - *There is some disagreement on the health care team: the nutritionist and pharmacist are pushing for tube feeding; the nursing staff is opposed; and the consultant radiologist is ambivalent, although he's not refusing to do the procedure.*
 - *Max and Jennifer are named as joint proxies in Mrs J's directive and instructed to make decisions together if questions arise that are not specifically dealt with in the content of the directive.*
 - *Mrs J's closest friend, Rita, has visited her in hospital. Rita is aware of the tube feeding proposal and has told the family physician that she doesn't think Mrs J would have wanted "to be hooked up to some machine."*

3. Review professional responsibilities

- a) Ask the residents to explain any professional responsibilities, policies, laws, or regulations that might apply to this case:
 - *Physicians should understand the basics of advance directives:*
 - *Directives only come into effect when the directive's author requires medical treatment and is unable to make or communicate decisions him- or herself.*
 - *Directives cannot contain requests for illegal activities.*
 - *Directives must meet certain legal requirements in terms of structure and format, which might vary from jurisdiction to jurisdiction.*

- *Directives can only be prepared by persons having the capacity to carefully consider potential future health care decisions.*
 - *Physicians should be aware of local laws regarding advance directives and should know how to access this legislation.*
 - *Physicians should be aware of local institutional policies regarding the use of advance directives, including requirements governing the inclusion of these documents in medical records and hospital charts.*
 - *Physicians should understand the requirements, responsibilities, and limitations of proxy decision making (eg, Mrs J's proxies are legally obliged to abide by Mrs J's previously stated wishes, despite any personal misgivings they might hold).*
 - *Physicians should understand the differences between various sorts of directives and how these differences might impact on patient care:*
 - *Verbal directives*
 - *Written directives: general, specific, proxy, combined (the directive being considered in this case appears to be a combined directive [ie, a mixture of general, specific, and proxy directives]. Mrs J has mentioned at least one specific request, but has also sought to leave matters of interpretation to her proxies).*
- b) Ask whether any of these standards conflict:
- *Physicians should understand that directives cannot contain requests for illegal or unprofessional interventions (there is no evidence of such a conflict in the current case discussion).*
- c) If a particular standard appears to bear directly on one of the action alternatives mentioned in parts 1 j) and 1 k), draw this to the residents' attention, as some action alternatives might be automatically ruled out.
- d) Provide the residents with directions to access necessary resources if they seem unaware of the case's relevant standards:
- *Links to relevant provincial legislation and regulations are provided at the end of this lesson plan.*

4. Identify relevant decision makers

- a) Ask for suggestions regarding the relevant decision makers:
 - *Ultimately, responsibility for the decision lies with the joint proxies in this case*
- b) While many decisions involve only the patient and the most responsible physician (MRP), other people often feel they have a say in the case. This is especially true of family members:
 - *In this case, relevant participants in the process might include the larger group of health care providers (eg, nurses, pharmacist, nutritionist, consultants) insofar as their opinions are likely to affect the proxies' interpretation of Mrs J's advance directive. The institution might also have an opinion, or perhaps even a policy, applicable to cases like this. It would be the MRP's responsibility to be aware of any such opinions/policies, through close consultation and discussion with other members of the health care team, including nursing, social work, etc.*
- c) Explore issues of competency, partial competency, dementia, immaturity, fear, depression, or other factors that might affect both the legitimacy and capability of the relevant decision makers:
 - *Mrs J is definitely not competent to make her own decisions regarding tube feeding; therefore, her advance directive comes into effect and her substitute decision makers will need to make the decision if this particular scenario is not specifically referenced in the directive. The family physician, while bearing responsibility for carrying out the chosen action, is not really a decision maker, but often will be a key influencing factor in the proxies' decision making process. In this case, there is no evidence that the proxies are unable or unwilling to decide, or that their decision will be unduly influenced by factors such as fear, guilt, mental anguish, etc.*
- d) Identify any possible conflicts of interest among the decision makers:
 - *Because Max and Jennifer hold opposing views regarding initiation of tube feeding, it would be important to carefully explore the reasons underlying their views. There is no*

obvious evidence in the case presentation to suggest that either of them stand to benefit personally from one of the action alternatives.

e) Identify the rights, roles, and responsibilities of surrogate decision makers if relevant:

- *Max and Jennifer have both the right and the responsibility to jointly make health care decisions on their mother's behalf. This role might be limited by specific requirements contained with the advance directive. They cannot overrule or decide contrary to a particular written request as long as the written request accurately addresses a current clinical context in which a decision is required. In other clinical matters not specifically identified in the directive and in matters that are only addressed in general terms, the proxies have the right and responsibility to decide to the best of their abilities, and in a manner consistent with their mother's previously expressed wishes, lifelong values, and best interests. This responsibility involves understanding their mother's "life story" and the relative importance or significance of the decision they need to make, as placed in the context of her personal narrative. It is important to note that proxies are not asked to make decisions based on their own personal values and belief systems; rather, these personal influences must be set aside when considering the well-being of the directive's author.*

f) While it is crucial to recognize family influences governing decision making, appropriate elements of confidentiality and informed consent must also be preserved:

- *There do not appear to be any confidentiality issues.*

5. Consider action alternatives

a) Review any action alternatives already suggested:

- *see 1j) and 1k) above*

b) On the basis of discussion to this point, ask the residents whether new action alternatives have become apparent:

- *Other possible courses of action might include temporizing measures, such as waiting for a few more days to see if Mrs J has less difficulty swallowing; improved appetite; or*

conversely, a significant decline in her current condition, such as what might occur following a second or third stroke.

- c) Rule out or modify action alternatives that directly conflict with therapeutic goals as voiced by competent patients or those that are illegal, impractical, against recognized policy, etc:
 - *Depending on interpretation, Mrs J's current challenges might be considered "irreversible and life-threatening" or they might not. Being entirely certain about this judgment is difficult because of the multiple factors at play: post-operative recuperation, stroke, mild renal failure, mild to moderate dementia, anorexia, swallowing difficulties, etc. However, tube feeding itself appears to fall directly into one of the categories specifically mentioned in the directive: "artificial life-prolonging interventions."*
- d) Ask the residents to remain as open as possible to any available options, even those that might be viewed as "fringe," non-medical, risky, unpopular, exotic, etc:
 - *For instance, ask residents if they know of any other means by which swallowing could be made safer for Mrs J, or whether her appetite could be improved with certain medications. Ask them to consider whether artificial hydration alone might allow the team a little more time to come to some consensus on future interventions.*
- e) To avoid polarizing the debate, try to resist the temptation to ask the residents to name the "right" or "ethical" alternative.

6. Identify values and principles supporting various alternatives

- a) Ask the residents to outline some of the values and principles they have in mind when they reflect on each action alternative.
- b) It sometimes helps to write down these values beside the proposed action alternatives. For example:
 - *The tube feeding option might be supported by a number of relevant values:*
 - *Compassion*
 - *Avoidance of possible discomfort associated with hunger in the context of inability to swallow*

- *Avoidance of possible discomfort that might follow aspiration pneumonia*
 - *Respect for and prolongation of life*
 - *Respect for the (substitute) autonomy of at least one of the proxies*
 - *Avoidance of denying what some would call routine sustenance*
 - *Possibly, adherence to the standards of the profession*
 - *Avoidance of tube feeding might be supported by a number of relevant values:*
 - *Compassion*
 - *Possibly, respect for autonomy, depending on the interpretation of the directive*
 - *Respect for the (substitute) autonomy of at least one of the proxies*
 - *Avoidance of artificially prolonging the dying process*
 - *Avoidance of unnecessary costs associated with futile interventions*
 - *Possibly, adherence to the standards of the profession*
 - *Note that the negative values, that is, the values that might underlie opposition to any of the preceding action alternatives have not been laid out in the same fashion as the supporting values. While this has been done for purposes of time efficiency, it would be important to raise these issues during the next stage of case analysis.*
- c) At this stage, try not to rank these values and principles. Instead, just recognize openly that most realistic courses of action are supported by legitimate and often deeply held values. This point will emphasize that ethics issues are controversial primarily for that reason: they bring values into conflict or competition.

7. **Weigh and balance various alternatives**

- a) Ask the residents to develop arguments in support of one or more particular course of action, as opposed to the other alternatives. Small-group discussions can be useful at this stage:
- *It might be more time efficient to separate into groups of five or six residents, each group attempting its own resolution of the case after hearing the ideas previously expressed during the large-group case discussion.*

- b) Remind the residents to apply their knowledge of ethical concepts and themes in family medicine, as well as the values they have identified underlying the action alternatives.
- c) When weighing and balancing various alternatives and their supporting values, suggest to the residents that there is no mathematical calculus—more often than not, the balance is not heavily weighted in one direction.
- d) Residents might suggest that there is no right answer in ethics. Try to resist this relativity trap. Your response might include some of the following suggestions:
- *In fact, there are often several right answers, insofar as several alternative courses of action can have strong ethical justification.*
 - In ethical dilemmas, we are usually looking for the *best possible* solution rather than the *only right* solution.
 - Sometimes, there are several good choices, each having equally weighted supporting arguments.
 - Sometimes, there are no good choices, but one still needs to choose. This is often referred to as the “lesser of many evils” scenario.
 - Sometimes, choosing to defer, to step back, or to temporize is the best possible course of action.
- e) Recognize the possibility of not coming up with a unanimously accepted solution. This happens relatively frequently—not everyone agrees at the end of the discussion, but all should agree that the reasons supporting the chosen course of action are valid, understandable, and fair.
- f) Occasionally, the discussion will get stuck or will stall. This presents an opportunity to ask the residents what they would do next if such a situation were to arise in real life. Options would include consultation with an ethicist or ethics committee, conversation with other colleagues, review of the relevant literature, etc. Keep in mind that many ethics decisions in medicine are not urgent. Reflection takes time:
- *In this case, other facts might turn up on further reflection. For instance, further discussion with Max and Jennifer might clarify Mrs J’s views regarding interventions*

like tube feeding near the end of life, or in a permanently compromised physical and mental state.

- *It would be important to help Max and Jennifer to focus on their mother's past behaviours, considering what they know she valued and desired over the many years they knew her while she still remained competent. The value of narrative ethics is apparent: Max and Jennifer need to place this decision in the context of their mother's life story, trying to understand how that story should guide their decision.*
- *The proxies should be reminded to focus on the goals of any therapy they might choose or reject on their mother's behalf. It is easy to get caught up in the intricacies and details of various therapies while ignoring the overall, long-term purpose of the therapy.*
- *The proxies need to understand that their roles as substitute decision makers require them to set aside, as much as possible, their own personal preferences and feelings, focusing instead on their mother's life, values, and current best interests.*
- *Although the proxies are ideally suited to perform this task due to their close relationship with Mrs J, it is still never easy. Family relationships can be exceedingly complex and their complexity can obscure the primary responsibility of the substitute decision maker.*
- *The family physician might be able to provide unique insights due to his or her recognition of patterns noticed in Mrs J's health care decision making over the many years the physician has known her.*
- *If asked for advice, it is morally acceptable and humanly desirable for the family physician to honestly state what he or she thinks should be decided, providing reasons for his or her opinion.*
- *If Mrs J's kidneys can tolerate it, temporization might be a reasonable option insofar as many uncertain clinical states tend to declare themselves with greater certainty over two or three days.*

- *Acceptance of the risks associated with ongoing attempts at oral feeding might be reasonable under the circumstances, particularly in the presence of some evidence showing no benefits for tube feeding in the context of severe dementia.*
- *When last assessed, her dementia was thought to be mild to moderate but the subsequent stroke could have further damaged her cognition.*
- *The additional costs associated with tube feeding are probably not significant enough to rule out this intervention, particularly in the context of hospital or nursing home confinement.*
- *Sensitive discussion is required concerning the differences between forced starvation (ie, forcibly denying a hungry person food) and not wanting to eat. While anorexia often accompanies advancing dementia, Mrs J's rejection of food, if due to fear of choking alone, can easily be addressed through tube feeding. Unfortunately, neither the family nor the health care team can be totally certain why she is rejecting food.*
- *While the proxies currently disagree, their motives do not seem suspicious. With time and further discussion, it is likely that they will come to some consensus regarding their mother's immediate future plans. They need to be reminded that while they are both named as proxies in the directive, they are also asked to make decisions jointly, and that it is their responsibility to resolve any ongoing disagreements so that the health care team can act with appropriate guidance.*
- *Help the residents to understand that advance directives often work better in theory than in practice. However, they are still good tools for initiating and facilitating discussions about important health care decisions in the context of lost capacity, which often occurs at or near the end of life. Ideally, family members and other potential proxies will have a fairly clear understanding of the patient's true intent, wishes, and desires. Exceedingly specific and detailed directives are exceptionally difficult to craft. Future events and therapies are often difficult to anticipate, and even when predicted accurately in terms of occurrence, they can be misinterpreted. For example, the possibility that a doctor might suggest surgery near the end of life might have been*

anticipated, while an in-depth understanding of the rationale and motivation for palliative surgery might be absent.

- *In this case, there appear to be good arguments and strong values supporting each of the two major action alternatives, and some other alternatives might be equally well-supported. Therefore, either alternative is morally justified, but any decision should be viewed as modifiable over the next few days or weeks. The proxies should be encouraged to re-discuss their decision with the health care team at regular intervals, maintaining a focus on Mrs J's comfort and well-being.*

8. Review the outcomes

- a) Remind the residents that one of the luxuries of case discussions is that no real patients are harmed as a result of the decisions made.
- b) In real life, patients are sometimes harmed, as are families and other parties to the process of medical decision making.
- c) If a real (but de-identified) case was presented, ask the resident who presented it to tell the group what really happened in the end. See how closely this resolution matches the preferred course of action as decided during the case discussion. Similarly, if the instructor presented the case, the ending can now be revealed:
 - *In this case analysis, no definite preferred course of action was identified. Emphasize to the residents that this is often what happens with ethical dilemmas. The important thing to keep in mind is that the reasons for acting or avoiding action were carefully considered and ethically justified. They were transparent and accepted as reasonable by all the people involved.*
 - *In the actual case, Max and Jennifer decided that they would not ask for tube feeding. They felt that Mrs J probably would not have wanted to artificially prolong her life in the context of dementia and hemiplegia. They also decided that she should be orally fed whatever foods she seemed to desire, even though they realized that the likelihood of her choking on her food put her at risk for contracting aspiration pneumonia. With the*

addition of a small amount of prednisone to her medications, Mrs J's appetite improved considerably over the following two weeks and her kidney function stabilized.

Preparations were made for her transfer to a long-term care facility and she seemed reasonably comfortable and content, although non-communicative. Unfortunately, she did develop pneumonia. Max and Jennifer decided against any further life-sustaining interventions after failure of an initial course of antibiotics and Mrs J died approximately six weeks following admission.

- d) While the preferred action alternative is often, and perhaps preferentially, the one that remains the most consistent with the weightiest values and most persuasive principles and arguments, there is little doubt that actual outcomes do matter.
- e) Ask the residents to consider whether the actual outcome of the real case was, in retrospect, the best possible outcome, as viewed through the eyes of those involved. Was it accepted and valued by the patient, the MRP, and the family? Did it achieve mutually-agreed-on goals? Did it involve the least amount of sacrifice or compromise of values and principles? Did it do the least harm to any other people involved in the case? Would the participants make the same decision again in similar circumstances?
- f) Emphasize that in real life, looking back at outcomes is crucial. It is not so much a matter of learning from one's mistakes as it is of developing an internal library of paradigm cases from which one can draw applicable and useful parallels in future case analysis. In other words, we can all get better at this and become more ethically mature through mindful, intentional reflection on the outcomes of troubling cases.

Further Reading

Links to provincial Acts and Regulations (accessed January 26, 2012)

British Columbia:

www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96405_01

(Representation Agreement Act)

www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/10_199_2001

(Representation Agreement Regulation)

www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181_01

(Health Care [Consent] and Care Facility [Admission] Act)

Alberta:

www.qp.alberta.ca/574.cfm?page=P06.cfm&leg_type=Acts&isbncln=9780779752935

(Personal Directives Act)

www.qp.alberta.ca/574.cfm?page=1998_026.cfm&leg_type=Regs&isbncln=9780779751747

(Personal Directives [Ministerial] Regulation)

www.qp.alberta.ca/574.cfm?page=2008_099.cfm&leg_type=Regs&isbncln=9780779733484

(Personal Directives Regulation)

Saskatchewan:

www.qp.gov.sk.ca/documents/English/Statutes/Statutes/H0-001.pdf

(The Health Care Directives and Substitute Decision Makers Act)

www.qp.gov.sk.ca/documents/English/Regulations/Regulations/H0-001R1.pdf

(The Health Care Directives and Substitute Decision Makers Regulations)

Manitoba:

<http://web2.gov.mb.ca/laws/statutes/ccsm/h027e.php>

(The Health Care Directives Act)

Ontario:

www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

(The Health Care Consent Act)

www.e-laws.gov.on.ca/html/regs/english/elaws_regs_960104_e.htm

(The Health Care Consent Act Ontario Regulation – Evaluators)

www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf

(Power of Attorney Forms)

Quebec:

www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FC_25%2FC25R3_A.htm

(Regulation respecting the conditions for the certification of notaries as regards to the institution or review of protective supervision and mandates in anticipation of incapacity)

New Brunswick:

<http://laws.gnb.ca/en/ShowPdf/cs/I-8.pdf>

(Infirm Persons Act)

Nova Scotia:

<http://nslegislature.ca/legc/statutes/persdir.htm>

(Personal Directives Act)

www.gov.ns.ca/just/regulations/regs/pdpersdir.htm

(Personal Directives Regulations)

Prince Edward Island:

www.gov.pe.ca/law/statutes/pdf/c-17_2.pdf

(Consent to Treatment and Health Care Directives Act)

www.gov.pe.ca/law/regulations/pdf/C&17-2G.pdf

(Consent to Treatment and Health Care Directives Act Regulations)

Newfoundland and Labrador:

www.assembly.nl.ca/legislation/sr/statutes/a04-1.htm

(Advance Health Care Directives Act)

Nunavut: [http://www.justice.gov.nu.ca/apps/search/docSearch.aspx?archived=0&what=personal+care+directives&fields=all&search=\(NOT+PATH+LIKE+'%25%5cTables%5c%25'\)&sort=rank&dir=asc&allLang=1&cp=5](http://www.justice.gov.nu.ca/apps/search/docSearch.aspx?archived=0&what=personal+care+directives&fields=all&search=(NOT+PATH+LIKE+'%25%5cTables%5c%25')&sort=rank&dir=asc&allLang=1&cp=5)

(Guardianship and Trusteeship Act)

Nunavut does not currently have an Act specifically governing the use of advance directives.

Northwest Territories:

www.justice.gov.nt.ca/PDF/ACTS/Personal%20Directives.pdf

(Personal Directives Act; no regulations as of January 2012)

Yukon:

www.gov.yk.ca/legislation/acts/dmspa.pdf

(Decision Making, Support and Protection to Adults Act)

www.gov.yk.ca/legislation/acts/dmspa.pdf#page=88

(Care Consent Act)

www.gov.yk.ca/legislation/regs/oic2005_080.pdf

(Care Consent Regulation)

Articles

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Emanuel LL, von Gunten CF, Ferris FD. Advance care planning. *Arch Fam Med* 2000;9:1181-1187.

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Sudore, RL, Fried TR. Redefining the “planning” in advance care planning: preparing for end-of-life decision making. *Ann Intern Med* 2010;153: 256-261.

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http://as01.ucis.dal.ca/dhli/cmp_advdirectives_faq/default.cfm. Accessed 2012 Jan 25.

Vogel L. Advance directives: obstacles in preparing for the worst. *CMAJ* 2011;183:E39-E40.
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Sample Lesson Plan 3

A. Physician Competence: Relevant CanMEDS Values and Themes

Values

- Good communication
- Patient safety
- Trust
- Accountability
- Honesty
- Reliability

Themes

- The need for clinical competence
- The need for professional attitudes
- The ethics of patient safety and medical error
- The need to contribute to system improvement
- Implications of the social contract
- Responsibilities to the profession
- Responsibilities to colleagues in difficulty

1. Introduce the topic

- a) Briefly present the following case. It can be electronically displayed or simply read aloud.

Case:

You are a family physician working in a community-based group practice. Your group includes six physicians, a nurse practitioner, a physiotherapist, and a part-time clinical pharmacist. Your clinic sees

patients for scheduled appointments five days and two evenings per week and the physicians share 24-hour on-call duties. You have worked at this clinic for approximately three years.

One of your senior colleagues, Dr Santos, age 60, has been a member of the group for many years. She has gradually decreased her clinic time over the past 18 months and as a result, her colleagues (yourself included) have frequently seen her regular patients in follow-up. You have begun to notice serious problems with her clinical management and record keeping. You have observed several instances of marked departure from well-recognized treatment guidelines, including the use of second- or third-line antibiotics for no apparent reason. Frequently, the management prescribed does not seem to match the briefly documented clinical presentation and you have noticed, with alarm, that at least two patients with acute onset chest pain do not appear to have been further investigated, even though multiple risk factors for cardiac disease are documented elsewhere in their medical records.

As time goes by, you become increasingly concerned both for the safety of Dr Santos' patients and for her own professional and personal well-being. Although you believe that serious harm might occur unless something is done, you are nervous about approaching her and are very hesitant to advise the local licensing authority. Eventually, you find the courage to approach another senior colleague in confidence. While this colleague admits that he's noticed the same sort of thing, he advises "Everyone knows she is a poor clinician – I've known her for 20 years and she was never too astute at the best of times. Leave it alone. She'll likely retire in a year or two."

You decide to watch things for a few more weeks. About three days later, Dr Santos sees one of your patients oncall in the clinic—a 2-year-old girl with painful urination. Although the chart note indicates "hurts to pee: fever, nausea, no appetite", there is no indication that a temperature was taken, or that urinalysis or urine dip was performed. There is no record of a physical examination, and the child was treated with an incorrect dose of a second-line urinary tract antibiotic. No follow-up plan was documented.

None of this would have come to your attention if the girl's mother had not called you to complain about their encounter with Dr Santos. After inquiring about the child's health (she is improving) you promise to "do something" about the unsatisfactory visit, but are left confused and upset about how to proceed.

- b) Alternatively, present a case from your own experience, involving concerns over a colleague's safety or competence. Stop short of telling residents "what happened" while presenting the case, reserving these details for the last step of the analysis process.
- c) After presenting the case, ask the residents to identify the main ethics topics that seem to arise within the case:
- *Probably, the topics "competence," "safety," or "duty to report" will be identified. You might say "I agree, this seems to be a case about safety and competence, but what other ethical issues might arise in this context?"*
- d) The residents might suggest some of the following relevant issues. It would be useful to write them down or display them for future reference:
- *Respect for a patient's right to safe health care*
 - *Protection of vulnerable populations (ie, patients in general)*
 - *Maintenance of professional standards*
 - *Responsibilities of self-regulation*
 - *Professional interactions with colleagues*
 - *Duty to report danger*
 - *Mechanisms for reporting*
 - *Risks of whistleblowing*
- e) If the list of identified issues is long, you might need to narrow the scope of the discussion by suggesting a few priority topics along the lines of the purposes stated immediately below.
- f) *The main purposes of today's case presentation:*
- *To highlight the physician's role in maintaining professional competence*
 - *To highlight the physician's duty to recognize and uphold professional standards*
 - *To examine the ethics of tensions within collegial relationships*
 - *To recognize the importance of patient safety and risk reduction*
 - *To understand the ethical foundations for a fiduciary relationship*

Restate the topic:

- g) After outlining the case, you should clearly restate the purpose of the session by explicitly identifying the priority topics:
- *Emphasize that this issue occasionally arises within the normal context of group family medicine practice. Because it can be very awkward when it occurs, prior discussion and reflection might be useful.*
- h) You might wish to highlight the topic's relevance in the context of the ethics curriculum competencies (Appendix 1). You might also wish to reference the applicable values and themes as identified in the document *Mapping Ethics Values to CanMEDS-FM Roles* (Appendix 2), some of which the residents will have already identified in step 1 d). A list of relevant values and themes is provided to instructors at the beginning of this lesson plan.
- i) At this point, it is probably counterproductive to get into a discussion regarding solutions to the case, although many residents will have already formed their own opinions.
- j) It is often useful to quiz the residents about their initial ideas regarding the ethical tensions by asking, "What is the problem in this case?" Typically, they will state the problem in terms of alternative possible courses of action, or *action alternatives*. Action alternatives form a natural beginning point to many case discussions in ethics, even though they arise at a later point in formal case analysis. In this case, the most obvious action alternatives are as follows:
- *The family physician could abide by his or her colleague's advice and ignore the mistakes Dr Santos is making.*
 - *The family physician could approach Dr Santos and confront her with the numerous concerns.*
 - *The family physician could report his or her concerns to the local licensing authority (College of Physicians and Surgeons [CPS]).*
 - *The family physician could suggest that the patient report her displeasure with Dr Santos to the CPS.*

- k) If you choose to have the residents suggest a few other possible action alternatives at this time, you should encourage them to do so without detailing their supporting arguments. You can state that the values underlying or supporting each of these proposed alternatives will be identified more clearly later on, along with an attempt to weigh and balance their relevance, applicability, and importance.

2. Review the facts of the case

- a) After the case has been presented, ask the residents whether there are other facts they would find useful. You can offer to make up important missing facts if you anticipate that the case discussion will work better with this information available:
- If you used the case provided in this lesson plan, there might be questions that demand more detail than what is provided. It is reasonable to make up such details, provided you anticipate this will contribute to a better case discussion. The details you provide might include a composite set of circumstances from your own experience in such situations.
- b) A convenient and useful way to gather all the necessary facts is to organize them into groups using a bio-psycho-social format. This is not always necessary, but it might help to avoid large gaps in data gathering:
- *While commonly useful, the biological portion of this fact-gathering exercise is probably not relevant to the current case. However, the psychological and social categories might remain useful groupings.*
- c) Emphasize that some facts such as medical prognosis and occasionally, diagnosis, cannot always be known with complete certainty, but that in real life, decision making must nevertheless proceed.
- *This analytical step is less relevant for the current case. Some facts, such as the local or jurisdictional requirements for reporting, might be initially unknown but eventually, discoverable.*
- d) In addition to biological facts, be sure to ask about psychological facts such as the patient's current state of mind and previously-stated therapeutic goals. Also ask about

social facts, which might include family context, religious and cultural factors, social support systems and relevant policies and laws.

- e) Facts that could prove useful for this particular case discussion might include the following:
- *Biological*
 - *This category is less relevant for the current case unless there is obvious evidence that Dr Santos is suffering from a physical illness that is somehow affecting her medical skills. Constant pain, for example, might contribute to distraction and errors.*
 - *If there is conclusive evidence that Dr Santos' practices are significantly substandard, her patients are at risk of physical harm.*
 - *Psychological*
 - *There is no evidence in the case to suggest that Dr Santos is suffering from addiction or dependency problems.*
 - *There is no evidence in the case to suggest that Dr Santos is suffering from a mental illness such as depression (affecting cognition) or dementia.*
 - *The problem has been noted over the last 18 months. Did Dr Santos experience loss of a loved one, a relationship breakup, or some other distraction affecting her medical judgment?*
 - *Does Dr Santos seem compromised in other regards? For example, has she been acting differently with respect to her colleagues? Has she seemed paranoid, suspicious, angry, or uncommunicative?*
 - *Have you overheard any recent interactions she has had with patients or with staff? Do they seem "normal" or are there worrisome aspects?*
 - *Social*
 - *There are six physicians in the group. Apart from the doctor already approached, have any of the others remarked on the apparent problems?*

- *How was your previous relationship with Dr Santos? The degree of nervousness about confronting her suggests lack of closeness, even though you have worked with her for at least three years.*
- *You are aware that the CPS will accept anonymous complaints but you know that it would be difficult to complain anonymously when the evidence you possess is something only a colleague would have.*
- *You remember that the CMA's Code of Ethics refers to your obligation to report unprofessional conduct by a colleague, but you can't remember the details of that requirement and you are not sure whether the medical mistakes you've been noticing are classified as unprofessional.*
- *You have heard that there is some sort of physician support group in your community but you think it is primarily for physicians who have had drug addiction problems.*
- *While you respect and enjoy working with your other colleagues in the practice, you are troubled by the advice you received from one of them. You know your colleagues well enough to believe that it would be safe to approach each of them individually about this matter, but you aren't sure whether this is the wise way to proceed.*
- *You are aware that Dr Santos and her husband purchased a retirement condominium in Arizona a few years ago and that she has been taking more frequent holidays there for the last year or so.*
- *You have no personal knowledge of Dr Santos' immediate family but you heard from one of your patients that Dr Santos' son and your patient's son are business associates.*

3. Review professional responsibilities

- a) Ask the residents to explain any professional responsibilities, policies, laws, or regulations that might apply to this case:

- *The CMA's Code of Ethics outlines some relevant professional responsibilities that apply to physicians, medical students, and residents:*
 - *Consider first the well-being of the patient.*
 - *Practise the art and science of medicine competently and without impairment.*
 - *Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege.*
 - *Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.*
 - *Seek help from colleagues and appropriately qualified professionals for personal problems that adversely affect your service to patients, society, or the profession.*
- *Most provincial regulatory bodies (ie, Colleges of Physicians and Surgeons) have made specific reference to the duty to report incompetent colleagues; for example:*
 - *The CPS (Saskatchewan), in its bylaws, has expanded on the previously noted CMA's Code of Ethics requirement, as follows: "Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by a colleague or concerns, based on reasonable grounds, that a colleague is practising medicine at a level below an acceptable medical standard, or that a colleague's ability to practise medicine competently is affected by a chemical dependency or medical disability."*
 - *The CPS (Manitoba), in its Bylaw #1 regarding Code of Conduct, states that: "Every member or associate member who reasonably believes that another member or associate member a) is unfit to practise, incompetent or unethical; or (b) suffers from a mental or physical disorder or illness that may affect his or her fitness to practise, and continues to practise despite having been counseled not to; must disclose that belief to the Registrar, along with the name of the other member or associate member and particulars of the suspected disorder, illness, lack of fitness to practise, incompetency or unethical behavior."*

- *Some health regions or institutions might have local jurisdictional policies affirming the duty to report incompetent or impaired health profession colleagues*
- b) Ask whether any of these standards conflict:
- *Although the standards mentioned in 3 a) all clearly describe a duty to report, they also refer to personal requirements for self-awareness and responsibility for maintaining one's own competence. Responsibilities to the patient, the profession, society, and oneself, while not internally conflicted, introduce complexities regarding the appropriate allocation of responsibility for taking action when problems become evident.*
- c) If a particular standard appears to bear directly on one of the action alternatives mentioned in parts 1j) and 1k), draw this to the residents' attention, as some action alternatives might be automatically ruled out:
- *In 1j), a few action alternatives have been suggested. The professional responsibilities noted in section 3 would suggest that the third, or possibly the fourth of these action alternatives are requirements of the profession.*
 - *The second action alternative mentioned is not automatically excluded by deciding to formally report your concerns to your provincial CPS.*
 - *The first action alternative mentioned seems less well-supported by well-recognized national and provincial standards, particularly if the risk of harm to patients is significant and imminent.*
- d) Provide the residents with directions to access necessary resources if they seem unaware of the case's relevant standards:
- *Links to provincial CPS websites or bylaws and regulations are included at the end of this lesson plan.*
 - *Local requirements will vary from jurisdiction to jurisdiction. Health regions and hospitals might make this information available to regional practitioners on their local websites.*

4. Identify relevant decision makers

a) Ask for suggestions regarding the relevant decision makers:

- *Since you are the physician who seems the most concerned about Dr Santos' competence, the decision about how to proceed is largely your own. However, you do not know for sure that none of your other colleagues have reported similar concerns. It is possible that the College is already well aware of the problem and is waiting for further confirmation before deciding to take action. It is also possible that Dr Santos has already been approached by the College, although this seems less likely.*
- *The patient who complained to you about Dr Santos might also have a personal stake in seeing that this unsatisfactory clinical encounter is reported. However, the case indicates that her child's health has not been seriously compromised, so she might choose to ignore the problem. Additionally, you left her with the impression that you would do something about the problem, so she might feel that it is no longer her responsibility.*
- *At least one of your colleagues seems to have noticed similar problems with Dr Santos' clinical performance. It seems fair to suggest that if you have a professional responsibility in this regard, he does too.*
- *Whether approached by you or contacted by the College, Dr Santos will have a personal responsibility to take immediate action. While it might be argued that she should have made this decision earlier, her apparent lack of insight could have prevented this from happening.*

b) While many decisions involve only the patient and the most responsible physician (MRP), other people often feel they have a say in the case. This is especially true of family members:

- *Unlike cases directly involving patients, this case is mostly concerned with how to manage awkward intraprofessional relationships. Other relevant decision makers will include any or all of your colleagues in the practice, should you choose to discuss the problem with them.*

- *The patient who contacted you has a stake in the appropriate resolution of this problem. While you need to maintain appropriate confidentiality, you could be asked by the patient for information regarding how you managed her initial complaint.*
- c) Explore issues of competency, partial competency, dementia, immaturity, fear, depression, or other factors that might affect both the legitimacy and capability of the relevant decision makers:
- *This analytical step is not relevant for the current case, apart from the background concern that Dr Santos' medical competency is in question and that there might be physical or psychological factors at play.*
- d) Identify any possible conflicts of interest among the decision makers:
- *You and your colleagues in the practice might be conflicted with respect to the fallout that might occur if you report your concerns. For example, you could be concerned that Dr Santos will become upset or angry with you, or accuse you of betraying her, or criticize you for threatening her livelihood.*
 - *You might be worried that your practice's reputation will be tarnished if reporting Dr Santos' results in a competency hearing or disciplinary action undertaken by the CPS, particularly if those proceedings are publicized.*
 - *You might be worried that negative publicity attached to your practice will affect future physician recruitment possibilities.*
 - *You might be concerned that if you don't report, your patient will feel compromised and will lose trust in both you and the medical profession.*
 - *You might feel internally conflicted if you are naturally inclined to avoid confrontation, yet feel a strong moral conviction to uphold the standards of the profession.*
 - *If any staff members in your clinic are approached regarding this issue, they could feel that if they speak freely, their jobs will be threatened.*
 - *Your patient might be disinclined to launch a formal complaint if family physicians are difficult to access in your community. She might think that complaining could result in*

her expulsion from your practice or a reduction in the level of service she might otherwise expect.

- e) Identify the rights, roles, and responsibilities of surrogate decision makers if relevant:
 - *This analytical step is not relevant for the current case.*
- f) While it is crucial to recognize family influences governing decision making, appropriate elements of confidentiality and informed consent must also be preserved:
 - *While typical family influences and interests are not relevant in this case, other aspects of confidentiality and privacy must be recognized. It would be important, for instance, for you to avoid discussing your concerns with individuals outside your practice.*
 - *If you decide to register your concerns with the authorities, it would be important to do so using established procedures and confidentiality safeguards.*
 - *You do not require your colleagues' consent before reporting Dr Santos to the CPS, nor do you need Dr Santos' consent.*

5. Consider action alternatives

- a) Review any action alternatives already suggested:
 - *See 1j) and 1k)*
- b) On the basis of discussion to this point, ask the residents whether new action alternatives have become apparent:
 - *The main action alternatives seem to involve either reporting or not reporting. However, if you choose to report, you still need to decide to whom you will report and how to report.*
 - *The residents might suggest that Dr Santos should be confronted first (either by you alone or by you and some of your colleagues) and depending on her response, take further action accordingly. This would be a reasonable action alternative.*
 - *The residents might suggest that your sample size is too small; that is, you need to look at more of Dr Santos' charts with an eye to documenting a pattern of incompetence*

before proceeding with a formal complaint. This would also be a reasonable action alternative.

- c) Rule out or modify action alternatives that directly conflict with therapeutic goals as voiced by competent patients or those that are illegal, impractical, against recognized policy, etc:
- *For the most part, this analytical step is not relevant for the current case. However, some residents might suggest that your responsibility to report is abundantly clear and that any other action alternatives, therefore, are automatically ruled out.*
 - *If this claim is made, instructors might decide to reserve comment until full discussion of the other action alternatives has taken place.*
- d) Ask the residents to remain as open as possible to any available options, even those which might be viewed as “fringe,” non-medical, risky, unpopular, exotic, etc:
- *This analytical step is less relevant for the current case. However, some residents might suggest that you “spy” on Dr Santos or eavesdrop on her conversations with patients to determine if your suspicions are well-founded.*
 - *Some residents might suggest that you tactfully survey other patients who have seen Dr Santos in clinic, asking whether they were satisfied with their interactions.*
 - *While both of these suggestions are ethically problematic, they should not be eliminated as possibilities without further discussion.*
- e) To avoid polarizing the debate, try to resist the temptation to ask residents to name the “right” or “ethical” alternative.

6. Identify values and principles supporting various alternatives

- a) Ask the residents to outline some of the values and principles they have in mind when they reflect on each action alternative.
- b) It sometimes helps to write down these values beside the proposed action alternatives. For example:
- *The option to follow your colleague’s advice and avoid doing anything about your concerns might be supported by a number of relevant values:*

- *Compassion for Dr Santos’ feelings*
- *Compassion for Dr Santos’ need to earn a living*
- *Compassion for Dr Santos’ family and friends if she is actively investigated*
- *Respect for Dr Santos’ prior contributions to the profession*
- *Protection of your own time and preservation of your inclination to avoid interpersonal and team conflict*
- *Awareness of the possibility you might be wrong or that the risk of harm for patients might be less than you have been led to believe*
- *Protection of the trust Dr Santos’ patients have placed in her*
- *Respect for an experienced colleague’s views*
- *The option to approach Dr Santos and confront her with your concerns might be supported by a number of relevant values:*
 - *Your ethical commitment to uphold the standards of the profession might be fulfilled, depending on her response*
 - *Nonmaleficence, or avoidance of harm, with respect to Dr Santos’ patients*
 - *Avoidance of uncomfortable, prolonged, or potentially public “official” interventions such as those that might occur following a complaint to the CPS*
 - *Respect for the protection of collegiality and team coherence*
 - *Avoidance of personal regrets over assuming the role of whistleblower*
 - *The possibility of helping a colleague with personal problems that might be temporary and fixable*
 - *Beneficence, (ie, protection of patient well-being), if Dr Santos takes your concerns seriously and immediately addresses practice deficiencies*
- *The option of registering your concerns regarding apparent medical incompetence with the provincial CPS might be supported by a number of relevant values:*
 - *From a longer-term perspective, you might be helping to protect Dr Santos’ career, which would make your action one of compassion and respect*

- *Achieving apparent consistency with the ethical requirements as set out in the CMA’s Code of Ethics*
- *Upholding the standards of the profession as laid out in provincial or institutional medical bylaws and codes of conduct*
- *Protection of the fiduciary relationship, (ie, protecting the public’s expectations of medical competence as the basis of a trusting relationship)*
- *Nonmaleficence and beneficence*
- *Protection of your practice’s public reputation*
- *Keeping a promise you made to your patient*
- *Protection of the profession’s moral claims regarding the rights and responsibilities of self-governance*
- *The option of suggesting to your patient that she report Dr Santos to the CPS herself might be supported by a number of relevant values:*
 - *Encouraging patients to exercise their rights to safe and effective health care is generally thought to advance the goals of the profession*
 - *Avoidance of collegial and interpersonal conflict and disruption*
 - *Avoidance of personal criticism for being a whistleblower or poor team player*
 - *Support for well-established CPS mechanisms and rationales regarding patient safety and patient rights*
- *The option of spying or eavesdropping on Dr Santos’ patient interactions might be supported by a few relevant values:*
 - *Fairness, with respect to increased certainty through documentation that patients are being placed in danger*
 - *Reinforcement of your resolve to take action as opposed to doing nothing*
 - *Avoidance of premature action or jumping to mistaken conclusions*
- *The option of surveying other patients might be supported by similar values.*

- *Note that the negative values, (ie, the values that might underlie opposition to any of the preceding action alternatives), have not been laid out in the same fashion as the supporting values. While this has been done for purposes of time efficiency, it would be important to discuss those reasons during the next stage of case analysis.*
- c) At this stage, try not to rank these values and principles. Instead, just recognize openly that most realistic courses of action are supported by legitimate and often deeply held values. This point will emphasize that ethics issues are controversial for exactly that reason; they bring values into conflict or competition.

7. Weigh and balance various alternatives

- a) Ask the residents to develop arguments in support of one or more particular course of action, as opposed to the other alternatives. Small-group discussions can be useful at this stage:
- *It may be more time efficient to separate into groups of five or six residents, each group attempting its own resolution of the case after hearing the ideas previously expressed during the large-group discussion.*
- b) Remind the residents to apply their knowledge of ethical concepts and themes in family medicine, as well as the values they have identified underlying the action alternatives.
- c) When weighing and balancing various alternatives and their supporting values, suggest to the residents that there is no mathematical calculus—more often than not, the balance is not heavily weighted in one direction:
- d) Residents might suggest that there is no right answer in ethics. Try to resist this relativity trap. Your response might include some of the following suggestions:
- *In fact, there are often several right answers, insofar as several alternative courses of action can have strong ethical justification.*
 - *In ethical dilemmas, we are usually looking for the best possible solution rather than the only right solution.*
 - *Sometimes there are no good choices, but one still needs to choose. This is often referred to as the “lesser of many evils” scenario.*

- *Sometimes, choosing to defer, to step back, or to temporize is the best possible course of action.*
- e) Recognize the possibility of not coming up with a unanimously accepted solution. This happens relatively frequently—not everyone agrees at the end of the discussion, but all should agree that the reasons supporting the chosen course of action are valid, understandable, and fair.
- f) Occasionally, the discussion will get stuck or will stall. This presents an opportunity to ask the residents what they would do next if such a situation were to arise in real life. Options would include consultation with an ethicist or ethics committee, conversation with other colleagues, review of the relevant literature, etc. Keep in mind that many ethics decisions in medicine are not urgent. Reflection takes time:
- *In this case, other action alternatives might turn up on further reflection. For example, some of the residents might suggest that you contact the local Physician Health Program, a service commonly provided by the provincial medical association. This program could confidentially approach Dr Santos, acknowledging that concerns have been raised and seeking to assist her with any modifiable factors affecting her ability to practise medicine competently.*
 - *If Dr Santos denies any problems and disputes any concerns about competence, the Physician Health Program might not have any further recourse. The CPS could intervene and demand a competency evaluation be undertaken by an independent assessor; however, this is unlikely to happen in the absence of formal complaints.*
 - *The residents might suggest that the patient complaint you have received and the charts you have reviewed do not constitute sufficient evidence to take action at this time. This is a legitimate argument and worthy of debate and discussion.*
 - *Two of the alternatives suggested above involve collection of further evidence, either surreptitiously or through questioning other patients. These options are problematic for many reasons. The first alternative involves deceit and subterfuge on your own part, not to mention purposeful breach of patient confidentiality without consent, while the second alternative could involve unnecessary threats to the fiduciary relationship, unwarranted*

suspicion, and similar breaches of confidentiality. You might also make matters worse by inadvertently prompting loyal patients to advise Dr Santos that you are “going behind her back” or seeking to discredit her for ulterior motives.

- *On deeper reflection, you might recognize that your desire to avoid confrontation is partially founded on fear. You might be worried that any criticism of your colleagues will result in your own medical practice being scrutinized. You are aware that there are few physicians, if any, whose practices are consistently beyond reproach.*
- *As mentioned in Appendix 2, a physician’s primary and overarching ethical duty is to “apply and integrate medical knowledge, clinical skills and professional attitudes in their provision of care.” This is echoed in the CMA’s Code of Ethics as the general responsibilities to “practise the art and science of medicine competently” and to “consider first the well-being of the patient.” However, our responsibilities are multi-layered and interdependent. Considering the patient’s well-being first does not preclude considering personal well-being and the well-being of one’s colleague.*
- *The medical and ethical norm of proportionality has relevance for this case. While College bylaws or regulations might seem to suggest that Dr Santos ought to be reported, to do so is a serious matter requiring firm justification. You would need to be convinced that her practice was not only suboptimal but imminently dangerous to future patients. The likelihood and degree of harm would need to significantly outweigh the multiple negative consequences that might occur should you choose to report.*
- *Possible consequences include permanent sacrifice of any hope for a collegial relationship with Dr Santos, disruption and distrust within your clinic, public embarrassment should Dr Santos be investigated and disciplined, legal proceedings initiated by Dr Santos against you and your colleagues, and even the possibility of suicide or violent retribution.*
- *It is important to recognize that provincial regulatory authorities are increasingly disinclined to use the heavy-handed approach they might have pursued in the past. The negative consequences mentioned above are far less likely to occur when discrete and*

confidential probing is initially undertaken. Educational options are now more frequently employed, with discipline being a last resort, reserved for recalcitrant cases and egregious conduct.

- *Although the ideal world rarely characterizes busy clinical practice, it would include developing group mechanisms for clinical quality control. Frequent shared review of clinical cases is a common learning tool in academic practices and a paradigm that merits extension into any group practice. In the case described, it would be much easier and much less threatening to Dr Santos to raise concerns about medical management in the context of quality control. Practically speaking, there are obvious time and money issues, especially in a fee-for-service environment, but periodic open review of each practitioner's medical management has great potential for improved patient outcomes and can contribute to a non-blaming culture of quality improvement within the profession.*
- *The residents might ask what they should do if they notice significantly substandard medical performance in one of their resident colleagues. Fortunately, most training programs have mechanisms to address such problems including peer counseling groups, faculty advisors, mentorship programs, and standardized evaluation or remediation programs. Faculty members are generally equipped and experienced enough to deal with discretely undertaking closer evaluation and observation, then intervening as necessary. Protection of confidentiality will be respected and enforced.*
- *On balance, the most supportable alternative might be to approach Dr Santos yourself, focusing on problems you have personally noted in dealing with patients who have previously been seen by her. This would avoid any concerns about "going behind her back" and could be combined with a sympathetic probing for causative factors. An offer of help in reviewing management of similar cases could be made, although this would carry the risk of other serious problems being revealed, followed by a more urgent obligation to report.*

- *Long term, you might offer to set up a combined “social hour and chart review” or similar intervention designed to include all of your colleagues, thereby acknowledging your shared professional responsibility for meeting the standards and improving quality of care.*

8. Review the outcomes

- a) Remind the residents that one of the luxuries of case discussions is that no real patients are harmed as a result of the decisions made.
- b) In real life, patients are sometimes harmed, as are families and other parties to the process of medical decision making.
- c) If a real (but de-identified) case was presented, ask the resident who presented it to tell his or her colleagues what really happened in the end. See how closely this resolution matches the preferred course of action as decided during the case discussion. Similarly, if the instructor presented the case, the ending can now be revealed:
 - *For the current topic, asking the residents to propose their own case might have been a little threatening. This is why it was not suggested at the beginning of the lesson plan. For other topics, having the residents present their own cases is a reasonable alternative to using the written case or presenting one of your own.*
 - *In the actual case, you eventually got up the nerve to approach Dr Santos after work one day. She was initially quite indignant and angry, but these emotions gave way to tears of shame within minutes. She admitted to you that she has been stressed out recently following the diagnosis of prostate cancer in her husband, a diagnosis of which you were previously unaware. She recognized that the cases you brought to her for discussion were inadequately documented and sub-optimally managed. She asked for your help in reviewing her charts for the past two months and identifying other obvious problems. She also advised you that she had decided to retire at the end of the calendar year. She thanked you for caring enough about her and her patients to do something and told you she admired your commitment to patient safety. Over the following months and up until her retirement, she came to you frequently to discuss medical management. While you*

often recognized ongoing deficiencies, none of them merited urgent intervention. You sometimes worry about not having reported your concerns to the CPS and wonder if you would actually have done so if Dr Santos had responded differently.

- d) While the preferred action alternative is often, and perhaps optimally, the one that remains the most consistent with the weightiest values and most persuasive principles and arguments, there is little doubt that actual outcomes do matter.
- e) Ask the residents to consider whether the actual outcome of the real case was, in retrospect, the best possible outcome, as viewed through the eyes of those involved. Was it accepted and valued by the patient, the MRP, and the family? Did it achieve mutually-agreed-upon goals? Did it involve the least amount of sacrifice or compromise of values and principles?
- *Not all of these questions are relevant for the current case analysis, but it appears as though the least damaging outcome was achieved without sacrificing any significant degree of patient safety. It is important to note that “. . . physicians possess a strong drive for achievement, exceptional conscientiousness, and an ability to deny personal problems. These attributes are advantageous for "success" in medicine; ironically, however, they may also predispose to impairment.”[§] Regardless of the reasons for impairment, we all have the obligation to remain vigilant in monitoring our own performance and the performance of our colleagues. Ignoring this responsibility would negate any claims we might make in support of professional self-governance.*
- f) Emphasize that in real life, looking back at outcomes is crucial. It is not so much a matter of learning from one’s mistakes as it is of developing an internal library of paradigm cases from which one can draw applicable and useful parallels in future case analysis. In other words, we can all get better at this and become more ethically mature through mindful, intentional reflection on the outcomes of troubling cases.

[§]Boisaubin EV, Levine RE. Identifying and assisting the impaired physician. *Am J Med Sci* 2001;322:31-36.

Further Reading

CMA Code of Ethics

<http://policybase.cma.ca/dbtrw-wpd/PolicyPDF/PD04-06.pdf>, Accessed 2012 Feb 7.

Links to provincial Colleges of Physicians and Surgeons and territorial regulatory bodies (Accessed 2012 Feb 12)

www.cpsbc.ca/ (CPS of British Columbia)

www.cpsa.ab.ca/Homepage.aspx (CPS of Alberta)

www.quadrant.net/cpss/index.html (CPS of Saskatchewan)

www.cpsm.mb.ca/ (CPS of Manitoba)

www.cpso.on.ca/ (CPS of Ontario)

www.cmq.org/ (CPS of Quebec)

www.cpsnb.org/ (CPS of New Brunswick)

www.cpsns.ns.ca/ (CPS of Nova Scotia)

www.cpspei.ca/ (CPS of Prince Edward Island)

www.cpsnl.ca/default.asp?m=1 (CPS of Newfoundland and Labrador)

www.yukonmedicalcouncil.ca/links.html (Yukon Medical Council)

www.hlthss.gov.nt.ca/english/health/default.htm (Northwest Territories Health and Social Services)

www.hss.gov.nu.ca/en/Home.aspx (Nunavut Health and Social Services)

Articles

Boisaubin EV, Levine RE. Identifying and assisting the impaired physician. *Am J Med Sci* 2001;322:31-36.

www.cmpa-acpm.ca/cmpapd04/docs/resource_files/web_sheets/com_w10_007-e.cfm

Canadian Medical Protective Association. Reporting another physician. Originally published December 2010. W10-007-E. Accessed 2012 Feb 12.

Resources

www.ephysicianhealth.com/

(ePhysicianHealth.com)

www.cma.ca/living/provincialphysicianhealthprograms

(CMA-sponsored links to provincial physician health programs)

Sample Lesson Plan 4

A. Continuity of Care in the Hospital Setting: Relevant CanMEDS Values and Themes

Values

- Patient-centred care
- Continuity of care
- Caring relationships
- Good communication
- Long-term commitment to patients
- Patient safety
- Trust
- Reliability

Themes

- The unique relationship family physicians have with their patients
- The ethics of team participation
- Wise use of scarce health care resources
- Advocacy for the health and well-being of communities and individual patients

1. Introduce the topic

- a) Briefly present the following case. It can be electronically displayed or simply read aloud.

Case:

While reviewing your tasks in the electronic medical record, you come across a pharmacy request for a medication renewal for one of your long-time patients, Preston N. The request indicates that some of his other medications were recently refilled but a few of them were not.

Because you usually try to synchronize their prescriptions when your patients are on several medications, you check your patient's dispensing history in the computerized provincial database and learn that the recent prescriptions were written by a physician at a walk-in clinic. You notice that one of Preston's antihypertensive medications has been stopped, two new ones started, and the dose of his diabetes medications has been changed. He has also been started on warfarin, apparently because of his atrial fibrillation.

While you respect your patient's autonomy and freedom to choose care providers, these changes puzzle and concern you. You also wonder about the latest prescription request and decide to ask your receptionist to phone Preston to advise him to see you in clinic tomorrow morning. In the morning, Preston does not arrive for his appointment and your receptionist tells you that she hasn't been able to reach him by phone. You reason that Preston will soon contact you if his prescriptions aren't filled and the matter fades into the background as you go about your daily work.

Two days later, you see a scanned copy of an emergency room report that seems to indicate Preston has been admitted to hospital. You cannot read most of the writing as the quality of the scanned image is poor. However, you can make out the words "chest x-ray" and "malignancy" along with the name of the admitting internist, Dr Davost. As you are reaching for the telephone to call the hospital to ask about Preston, another electronic task appears in your EMR, this one indicating that a message has been left for you to call Preston's nephew. The message reads: "Preston in hospital. Chest full of cancer. Call as soon as possible."

Preston is 83 and suffers from hypertension, diabetes, congestive heart failure, COPD, and atrial fibrillation. Eleven months ago, he underwent bowel resection for locally invasive colon cancer after being hospitalized for investigation of rectal bleeding. This was followed by six months of chemotherapy. At the time of his surgery he was also noted to have extensive diverticular disease. He seems to have recovered reasonably well from his cancer treatments and still lives at home alone. However, he is finding it increasingly difficult to come to clinic, so you have visited him in his apartment a couple of times over the past five months. His only family is a niece and nephew, both of whom see him on a regular basis. Home Care nursing attends on a weekly basis to help him organize his medications. Recently, you saw a visit report indicating that they told Preston to remember to wear

his pressure stockings, but you are pretty sure that he cannot bend over well enough to put on his pressure stockings.

When you speak to Preston's nephew by telephone, you are told that Preston was informed he was "cancer-free" at his last oncology appointment five months ago. Therefore, the news about the chest x-ray is a big shock for the family. You are also told that the insulin he brought from home was lost by the hospital, that his diuretic was never provided after admission, and that Preston has not been informed about any plans for investigation and management. You promise to go to the hospital after work that evening and when you arrive, Preston is sitting on the edge of his bed, obviously short of breath, and visibly angry. He tells you that his nose has been bleeding because of the oxygen nasal prongs, his nurse just scolded him for not finishing his supper and he hasn't seen his doctor yet, even though this is his third full day in hospital.

You spend some time with Preston and then read through his hospital chart, which indicates that he was admitted for treatment of urosepsis. The documented history is fairly consistent with what you know about him but his heart failure history is missing and there is significant confusion about his medications. His niece is listed as his daughter in the "next-of-kin" section. Your name is missing as the family physician. The date of his last chemotherapy treatment is off by 12 months, there is a note about his being a current smoker (he quit 37 years ago), and there is no mention of the advance directive you helped Preston prepare a few months ago. When you try to call Dr Davost to discuss some of these inconsistencies you are told by the switchboard that he is out of town at a convention for three days and that Dr Murray will be managing his inpatients. Dr Murray isn't answering his pager this evening. You leave a note in the chart, asking him to call you.

When you arrive at your clinic in the morning, you open your EMR and find that the first hour in your schedule has been blocked off to meet with Preston's niece and nephew. Your receptionist has flagged the appointment, indicating that the couple is upset and wanting answers about "missed follow-up for cancer."

- b) Alternatively, present a case from your own experience, involving the unique and central role a family physician can play in continuity of care relationships. Stop short of telling residents "what happened" while presenting the case, reserving these details for the last step of the analysis process.

- c) After presenting the case, ask the residents to identify the main ethics topics that seem to arise within the case:
- *Probably, the topics “hospital errors,” “specialist mix-ups,” “poor communication,” “missed follow-up,” and “angry families” will be identified. You might say, “I agree, this case includes several elements involving things going wrong, but what other ethical issues might arise in this context?”*
- d) The residents might suggest some of the following relevant issues listed below. It would be useful to write them down or display them for future reference:
- *A family physician’s role in hospital care*
 - *Advocating for patients, particularly those most vulnerable*
 - *A family physician’s role in monitoring patient safety and addressing errors*
 - *Contributions to system improvement*
 - *Contributions to team-based care*
 - *Responsibilities for collaboration, partnering, and good communication*
- e) If the list of identified issues is long, you might need to narrow the scope of the discussion by suggesting a few priority topics along the lines of the purposes stated immediately below.
- f) *The main purposes of today’s case presentation:*
- *To highlight the family physician’s role in contributing to quality hospital care*
 - *To highlight the family physician’s role in advocating for vulnerable patients*
 - *To highlight the family physician’s role as a conduit of accurate information*
 - *To highlight the family physician’s role as a good communicator, mediator, and repository of valuable family contextual information*
 - *To understand the values underlying these roles*

Restate the topic:

- g) After outlining the case, you should clearly restate the purpose of the session by explicitly identifying the priority topics:
- *Emphasize that a unique relationship with our patients characterizes the practice of family medicine. One of the four foundational principles for our discipline states that “The doctor-patient relationship is central to the role of the family physician.” One of the three foundational concepts for the Triple C Competency-based Curriculum is continuity of care. Our long-term commitment to patients is perhaps family medicine’s most defining feature, and also the one that can bring its practitioners the most satisfaction.*
- h) You might wish to highlight the topic’s relevance in the context of the ethics curriculum competencies (Appendix 1). You might also wish to reference the applicable values and themes as identified in the document *Mapping Ethics Values to CanMEDS-FM Roles* (Appendix 2), some of which the residents will have already identified in step 1 d). A list of relevant values and themes is provided to instructors at the beginning of this lesson plan:
- *Of the seven roles defined in CanMEDS-FM, perhaps only “scholar” has a lesser relevance in this case.*
- i) At this point, it is probably counterproductive to get into a discussion regarding solutions to the case, although many residents will have already formed their own opinions.
- j) It is often useful to quiz the residents about their initial ideas regarding the ethical tensions by asking, “What is the problem in this case?” Typically, they will state the problem in terms of alternative possible courses of action, or *action alternatives*. Action alternatives form a natural beginning point to many case discussions in ethics, even though they arise at a later point in formal case analysis. In this case, the most obvious action alternatives are as follows:

- *The family physician could avoid getting involved in Preston’s hospital care and advise Preston’s relatives to contact the cancer agency if they have concerns about his cancer follow-up.*
 - *The family physician could visit Preston in hospital but avoid getting involved in his hospital management. The family physician could also meet with Preston’s relatives to hear their concerns.*
 - *The family physician could leave tactful remarks in the “progress notes” in Preston’s hospital chart to correct misinformation and suggest different management, while encouraging the family to contact both Dr Davost and the cancer agency to discuss their concerns.*
 - *The family physician could write orders in Preston’s chart so as to correct perceived inadequacies in management and also make corrections to the admitting history, while continuing to visit Preston regularly.*
 - *The family physician could contact Dr Davost or his designate to arrange a meeting to discuss Preston’s care, while continuing to visit Preston regularly. The family physician could also meet with Preston’s relatives to discuss their concerns.*
 - *Various other combinations of actions or non-actions could be considered.*
- k) If you choose to have the residents suggest a few other possible action alternatives at this time, you should encourage them to do so without detailing their supporting arguments. You can state that the values underlying or supporting each of these proposed alternatives will be identified more clearly later on, along with an attempt to weigh and balance their relevance, applicability, and importance.

2. Review the facts of the case

- a) After the case has been presented, ask the residents whether there are other facts they would find useful. You can offer to make up important missing facts if you anticipate that the case discussion will work better with this information available. Some suggestions are offered in part e), below.

- If you used the case provided in this lesson plan, there might be questions that demand more detail than what is provided. It is reasonable to make up such details, provided you anticipate this will contribute to a better case discussion. The details you provide might include a composite set of circumstances from your own experience in such situations.
- b) A convenient and useful way to gather all the necessary facts is to organize them into groups using a bio-psycho-social format. This is not always necessary but it might help to avoid large gaps in data gathering.
 - c) Emphasize that some facts such as medical prognosis and occasionally, diagnosis, cannot always be known with complete certainty, but that in real life, decision making must nevertheless proceed.
 - d) In addition to biological facts, be sure to ask about psychological facts such as the patient's current state of mind and previously-stated therapeutic goals. Also ask about social facts, which might include family context, religious and cultural factors, social support systems, and relevant policies and laws.
 - e) Facts that might prove useful for this particular case discussion might include the following:
 - *Biological*
 - *Several of Preston's diagnoses are well-known, and pre-date his hospital admission. Some of them will almost certainly impact his hospital care and perhaps affect any new diagnoses in terms of prognosis and management.*
 - *Because Preston was apparently admitted for treatment of a systemic infection (urosepsis), you are not entirely clear why a chest x-ray was performed. Unfortunately, it has revealed new and potentially life-threatening changes in Preston's lungs.*
 - *Although he quit many years ago, Preston is a previous cigarette smoker and therefore is at higher risk of developing a primary lung cancer.*
 - *Preston's previous history of COPD could impact the symptoms he will experience with the progression of any new respiratory disease.*

- Preston’s recent cancer diagnosis likely places him at higher risk of developing another malignancy. Although he underwent surgery and chemotherapy for apparent Stage III colon cancer, he could now be experiencing a metastatic recurrence.
- While the urosepsis for which he was admitted is being adequately treated with antibiotics, his lung diagnosis remains unknown, pending biopsy results.
- At age 83, Preston’s several chronic illnesses present a considerable threat to his longevity and ability to withstand yet another life-threatening diagnosis and any treatment that might be proposed.
- Preston has always struggled with weight control.
- *Psychological*
 - Preston is intelligent and cognitively intact.
 - Preston has told you several times that he is not afraid of dying.
 - Preston completed an advance directive six months ago with your guidance, in which he asks that aggressive therapies such as curative surgery, admission to ICU for ventilation, and cardiorespiratory resuscitation be avoided if there is little chance of success or illness reversal.
 - Preston has never been depressed and does not appear to be depressed at this time.
 - Preston is a precise and organized thinker, having worked as a mechanical engineer for most of his career. While typically astute, he is also trusting and respectful of medical practitioners.
 - Preston is generally a good-natured man, whom you think of as kind, articulate, and given to friendly banter.
 - Preston has always been realistic about his chronic illnesses. He readily acknowledges that one or more of them are going to “catch up with him” sooner or later.

- *Preston likes to be in control of his surroundings. You guess that his current disgruntled demeanor relates to an unexpected loss of autonomy and perhaps to fear regarding the surprising x-ray results.*
- *Although Preston had been told by the oncologists that his cancer had been cured, he has told you more recently that he knows cancer has a way of coming back. He has remarked that he would rather have a good, definitive heart attack before that happens.*
- *Although Preston is practical and realistic, he is also typically optimistic. He has always been willing to experiment with new medical therapies, but only after gaining a reasonable understanding of how they work, along with their expected risks and benefits.*
- *Social*
 - *Preston has never been married. Once he told you that he just never seemed to find the right girl.*
 - *He is an excellent cook and loves to experiment with new recipes, not all of them advisable in light of his diabetes and heart failure. You have discussed his elevated cholesterol with him on several occasions but he usually remarks that “life is too short to spend much time worrying about lab results.”*
 - *There is little in the way of family members. He had only one brother, now deceased. He remains very close to his brother’s daughter (his niece). She and her husband maintain frequent contact with Preston. They have two children who also visit frequently.*
 - *Preston lives alone in an apartment building and manages fairly well with minimal support. Home care nursing attends once weekly to help him organize his numerous medications and manage incidental problems with his health. He is not convinced he needs this help but has agreed to the arrangement because his niece set it all up.*

- *He has been retired for 20 years and was previously employed with the city’s engineering department. He has no financial concerns.*
- *Preston doesn’t get out of the apartment as much as he used to. He has a few close friends but their health is also failing and he sees them less often than he would like. You believe he has expressed a degree of loneliness in this regard.*
- *Preston has no strong religious beliefs, although he lists “United Church” as his religious affiliation on the hospital admission form.*
- *Dr Davost is a well-respected and astute internist with heavy teaching responsibilities. It struck you as odd that Preston’s chart contains no notes made by internal medicine residents.*
- *As a family physician, you have always enjoyed providing hospital care for your patients. However, some colleagues in your family medicine practice do not share this view, which has led to complex work-sharing and financial arrangements and occasionally, a certain amount of friction.*

3. Review professional responsibilities

- a) Ask the residents to explain any professional responsibilities, policies, laws, or regulations that might apply to this case:
 - *It would be unusual for a hospital, health region, or licensing authority to require the family physician to attend a patient in hospital if the patient has been admitted under the care of another physician.*
 - *In communities with hospitals staffed only by family physicians, there would be an obligation to provide inpatient care as determined by local work-sharing agreements, acceptable degree of patient acuity, personal scope of physician practice, and local availability of diagnostic and therapeutic resources. In the current case, these considerations are not relevant.*
 - *There is no obvious professional standard that would require you to initiate communication with the admitting specialist. However, you have freely chosen to visit*

Preston in hospital and to read his hospital chart. You have recognized that the chart contains several errors, some of which might impact negatively on Preston's care if they are not rectified. This creates an unofficial but compelling professional responsibility.

- *There might be local institutional policies requiring the notification of family physicians on admission of their patients to hospital. It is unlikely that these policies would require admitting specialists to communicate with or actively involve their family medicine colleagues. However, minimal traditional professional standards would require admitting specialists to provide family physicians with discharge summaries detailing hospital care provided to patients, along with any plans for family physician follow-up.*
- *Family physicians should be aware that any visits they make to patients in hospital might tend to prompt patient expectations for ongoing visits. Even though they are not listed as MRP, family physicians might be viewed by these patients as active participants and care-related inferences might be made.*
- *The CFPC strongly encourages family physician involvement in hospital-based care, but this encouragement does not take the form of official policy.*
- *The CMA's Code of Ethics states: "Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient, or until the patient has been given adequate notice that you intend to terminate the relationship." Owing to the ways in which modern medical care is parceled and delivered, it would be difficult to argue that "continuous provision of services" implies an obligation for any one physician to be the sole ongoing provider.*
- *The CMA's Code of Ethics implores us to "Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services." While this standard does not directly require family physicians to participate in hospital care, it serves to emphasize the importance of working together with our colleagues to achieve a common goal: optimal outcomes for patients. This in*

turn might imply certain responsibilities with respect to error correction and clarification of patient and management goals.

- b) Ask whether any of these standards conflict:
- *Because there appears to be little in the way of law, policy, or professional standards that would require the family physician to participate in hospital care, it might be argued that you have no official obligations in Preston's case and that conflicting standards are not an issue.*
- c) If a particular standard appears to bear directly on one of the action alternatives mentioned in parts 1j) and 1k) draw this to the residents' attention, as some action alternatives might be automatically ruled out:
- *None of the action alternatives suggested in part 1j) is directly ruled out by law, policy, or professional standards. However, if you become aware of errors, significant inaccuracies, or other worrisome elements of Preston's care, it might be argued that for reasons presented in more detail in parts 6 and 7, professional standards oblige you to take some sort of corrective action.*
- d) Provide the residents with directions to access necessary resources if they seem unaware of the case's relevant standards:
- *Despite the absence of official laws or policies, and notwithstanding the inferences that might be drawn from certain CMA Code of Ethics segments, the resources included at the end of this lesson plan under "Further Reading" might be of interest to residents concerned with professional association opinion and commentary.*

4. Identify relevant decision makers

- a) Ask for suggestions regarding the relevant decision makers:
- *Any decisions about the extent to which you involve yourself in Preston's hospital care are largely your own. However, once you choose to be involved beyond simple social visits at the bedside, any management decisions you make become subject to team scrutiny and discussion. Obviously, therapeutic and management decisions should only*

be undertaken with Preston's knowledge and agreement, along with the most responsible physician's (MRP's) agreement.

- b) While many decisions involve only the patient and the MRP, other people often feel they have a say in the case. This is especially true of family members:
- *It is evident that Preston's niece and nephew are closely involved in his life and social context. The case presentation suggests they also wish to be involved in his medical care, at least insofar as playing a meaningful advocacy role.*
- c) Explore issues of competency, partial competency, dementia, immaturity, fear, depression, or other factors that might affect both the legitimacy and capability of the relevant decision makers:
- *There is no evidence to suggest that real or potential decision makers are in any way compromised or that undue influences are being intentionally exerted.*
- d) Identify any possible conflicts of interest among the decision makers:
- *This standard analytical consideration raises interesting, infrequently discussed aspects of inpatient care. On the one hand, not becoming involved with Preston's hospital care is by far the easiest route for you to take. It maintains clearly defined boundaries outlining responsibility for medical decision making and raises no thorny issues regarding competition for and "ownership" of patients. Moreover, choosing not to be involved might avoid the loss of financial income some family physicians associate with inpatient care.*
 - *In contrast, becoming involved in Preston's hospital care introduces the many complexities of membership in team-based care provision. While there are usually well developed institutional protocols for team member interactions and lines of accountability, background concerns around turf protection, interference, and competition for patients might well exist, depending on the history and traditions of the local hospital and community practice milieu.*
 - *Over time, family physicians have gradually decreased their involvement in hospital-based care for a number of reasons, particularly in urban communities. The rise in*

hospitalist-provided and specialty-based inpatient care might be accompanied by a decreasing awareness of the special contributions a family physician can make. This lack of awareness might be experienced by some family physicians as unwelcoming hospital environments if not outright discouragement or disregard.

- e) Identify the rights, roles, and responsibilities of surrogate decision makers if relevant:
- *This step does not apply to the current case, except to say that Preston's relatives need to be considered as potential future surrogates. It would be important to confirm this preference with him while he is still competent, regardless of whether you become involved with his hospital care.*
- f) While it is crucial to recognize family influences governing decision making, appropriate elements of confidentiality and informed consent must also be preserved:
- *Because Preston is very close to his niece and nephew and because he has no other immediate family, it seems reasonable to suggest they will have a significant influence on his medical decision making.*
 - *However, their request to meet with you to discuss Preston's cancer follow-up presents some immediate challenges to well-recognized principles of confidentiality and privacy. The easiest solution, of course, would be to obtain Preston's consent before meeting with them, asking him whether you are free to discuss any or all of his health care matters. You could talk to Preston about this first thing in the morning, before your scheduled appointment with his niece and nephew.*
 - *If he provides it, you should document Preston's consent in his clinic chart and probably in the hospital chart as well. You should try to achieve clarity with him regarding any roles his niece and nephew might play in medical decision making both now and in the future.*

5. Consider action alternatives

- a) Review any action alternatives already suggested:
- *See 1j) and 1k)*

- b) On the basis of discussion to this point, ask the residents whether new action alternatives have become apparent:
- *The main action alternatives seem to involve either avoiding contact entirely while Preston is hospitalized, or getting involved at various levels of engagement.*
 - *A decision also needs to be made about whether you will meet with his relatives to discuss their concerns. If you decide to do this (assuming Preston provides consent) you will then need to decide what to say and do about their concerns, if anything.*
 - *On a systemic level, you might need to make your decision in the context of strong preferences expressed by your practice group and hospital colleagues. For example, do any of your community's family medicine colleagues admit patients to hospital? Do other members of your practice offer inpatient care? Do you have on-call arrangements in place for coverage of inpatients? Is shared-care with specialist colleagues a commonplace practice for hospitalized patients in your community? Are you familiar with the preferences of Preston's current MRP?*
- c) Rule out or modify action alternatives that directly conflict with therapeutic goals as voiced by competent patients or those that are illegal, impractical, against recognized policy, etc:
- *Undoubtedly, Preston would greatly appreciate your involvement in his hospital care. This sentiment is almost universally expressed by hospitalized patients who have a longstanding relationship with a family physician.*
 - *Presumably, you are more aware of Preston's therapeutic goals than any other health care provider. You also know him well enough to easily gauge whether those goals are changing in response to new symptoms, diagnoses, and practical realities.*
 - *The degree to which your involvement in Preston's hospital care can be considered practical depends on your unique practice environment. For example, if you work in a large city, do not typically admit patients to hospital, and do not even have parking privileges at the hospital in question, it is possible that daily visits to inpatients will seem impractical.*

- *It is highly unlikely that law, policy, or standards will prevent you from becoming involved at some level. However, you would need to be aware of any restrictions placed on your contributions subject to institutional rules governing admission and inpatient treatment privileges.*
- d) Ask the residents to remain as open as possible to any available options, even those which might be viewed as “fringe,” non-medical, risky, unpopular, exotic, etc:
- *This consideration is not relevant for the current case.*
- e) To avoid polarizing the debate, try to resist the temptation to ask residents to name the “right” or “ethical” alternative.

6. Identify values and principles supporting various alternatives

- a) Ask the residents to outline some of the values and principles they have in mind when they reflect on each action alternative.
- b) It sometimes helps to write down these values beside the proposed action alternatives. For example:
- *The option to avoid getting involved in Preston’s hospital care while advising Preston’s relatives to contact the cancer agency if they have concerns about his cancer follow-up might be supported by a number of relevant values:*
 - *Avoid “stepping on toes” with respect to intraprofessional interactions*
 - *Time efficiency: overall, it could be argued that more “good” might be accomplished by staying in your clinic and seeing outpatients (a utilitarian perspective)*
 - *It might be argued that avoiding hospital care is a more rational use of scarce health care resources (good stewardship)*
 - *It is simpler and less stressful, personally*
 - *Avoidance of conflict with your practice colleagues, particularly those for whom your hospital visits might set unwelcome precedents and new expectations*

- *Might achieve better accuracy with respect to providing Preston's relatives with first-hand explanations regarding the actual cancer follow-up rather than your interpretation of what happened*
- *The option to visit Preston in hospital but avoid getting involved in his hospital management, while meeting his family to hear their concerns might be supported by a number of relevant values:*
 - *Maintains some semblance of continuity insofar as Preston being assured of your ongoing knowledge of his progress*
 - *Reassures Preston that you care about his health and well-being*
 - *Maintains a measure of trust and reliability*
 - *Serves the instrumental value of staying connected with evolving health status, which reduces the complexity of needing to "catch up" through oft-delayed discharge summaries*
 - *Promotes family physician visibility in the hospital, at least on a superficial level*
 - *To meet with the niece and nephew would be respectful of family involvement and the relevance of social context, provided Preston has consented to this option*
 - *The family physician can sometimes reduce or eliminate anger while defusing potential conflict up to and including legal strife, through sympathetic listening and careful interpretation of the available data*
 - *When there have been lapses in appropriate follow-up, the family physician can advocate with the family on the patient's behalf*
- *The option to leave tactful remarks in the progress note section of Preston's chart while encouraging his relatives to contact both the MRP and the cancer agency might be supported by a number of relevant values:*
 - *When combined with regular visits to Preston, this option promotes similar values to those outlined immediately above*
 - *Notes in the chart (as opposed to contradictory orders) might be more readily accepted by the MRP and viewed as helpful rather than antagonistic or intrusive*

- Valuable goals of error reduction and improved safety might be served if your notes are actually read and acted on
 - Although it could be viewed as “passing the buck,” redirection of the family’s concerns to the MRP and the cancer agency might also be viewed—at least by the specialists involved—as more collegial and respectful of their roles
 - The option of making actual changes to Preston’s management orders and admission data while continuing to visit him daily might be supported by a number of relevant values:
 - Increased accuracy and therefore, potentially increased safety
 - Clarity, reduced chance of being overlooked
 - All of the values mentioned earlier in relation to visiting Preston
 - The option of contacting Dr Davost or his designate to arrange a meeting, while continuing to visit Preston and meeting with his family members might be supported by a number of relevant values:
 - Added to many of the values named earlier are the values of good communication and the possibility of effective team participation
 - An advocacy role and protection of Preston’s interests can be better served through team membership
 - Quality improvement through improved patient-doctor communication is more likely when the communicators are well known to each other
 - Note that the negative values (ie, the values that might underlie opposition to any of the preceding action alternatives) have not been laid out in the same fashion as the supporting values. While this has been done for purposes of time efficiency, it would be important to discuss those reasons during the next stage of case analysis.
- c) At this stage, try not to rank these values and principles. Instead, just recognize openly that most realistic courses of action are supported by legitimate and often deeply held values. This point will emphasize that ethics issues are controversial for exactly that reason; they bring values into conflict or competition.

7. Weigh and balance various alternatives

- a) Ask the residents to develop arguments in support of one or more particular course of action, as opposed to the other alternatives. Small-group discussions can be useful at this stage:
 - *It might be more time efficient to separate into groups of five or six residents, each group attempting its own resolution of the case after hearing the ideas previously expressed during the large-group discussion.*
- b) Remind the residents to apply their knowledge of ethical concepts and themes in family medicine, as well as the values they have identified underlying the action alternatives.
- c) When weighing and balancing various alternatives and their supporting values, suggest to the residents that there is no mathematical calculus—more often than not, the balance is not heavily weighted in one direction.
- d) Residents might suggest that there is no right answer in ethics. Try to resist this relativity trap. Your response might include some of the following suggestions:
 - *In fact, there are often several right answers, insofar as several alternative courses of action can have strong ethical justification.*
 - *In ethical dilemmas, we are usually looking for the best possible solution rather than the only right solution.*
 - *Sometimes there are no good choices, but one still needs to choose. This is often referred to as the “lesser of many evils” scenario.*
 - *Sometimes, choosing to defer, to step back, or to temporize is the best possible course of action.*
- e) Recognize the possibility of not coming up with a unanimously accepted solution. This happens relatively frequently—not everyone agrees at the end of the discussion, but all should agree that the reasons supporting the chosen course of action are valid, understandable, and fair.
- f) Occasionally, the discussion will get stuck or will stall. This presents an opportunity to ask the residents what they would do next if such a situation were to arise in real life.

Options would include consultation with an ethicist or ethics committee, conversation with other colleagues, review of the relevant literature, etc. Keep in mind that many ethics decisions in medicine are not urgent. Reflection takes time:

- *According to CIHI, the proportion of Canadian family physicians providing hospital care fell from 71% to 62% over the period 1992 to 2001. The CFPC has more recently noted similar trends.***
- *“Family physicians in small towns (51%) and rural areas (54%) [are] much more likely to provide inpatient hospital care than FPs practicing in cities (16%) and suburban areas (26%).”***
- *Dr Cal Gutkin, CEO of the CFPC, has written: “The value to hospitalized patients of having skilled and knowledgeable family physicians providing bedside care, coordinating the services of other health care workers, advocating for them, and ensuring that all hospital caregivers understand them as people with an important past and a meaningful ongoing role within their families and communities cannot be underestimated.”††*
- *The reasons for decreased participation in hospital care are numerous and varied. Changes in physician demographics, introduction of advanced technologies, inadequate remuneration, poor access to specialist consultants, increasing tendency for new family physicians to focus their practices, limited access to hospital beds, increased office workloads, increased patient acuity and complexity, and unwelcoming environments as a result of hospital or regional restructuring have all been cited as possible explanations.*
- *Opportunities for strong patient advocacy, combined with better coordination and continuity of care, are the primary benefits seen for both patients and family physicians practising inpatient care.*

**College of Family Physicians of Canada. *Family Physicians Caring for Hospital Inpatients: A Discussion Paper*. Mississauga, ON: College of Family Physicians of Canada; 2003. Available from: www.cfpc.ca/uploadedFiles/Resources/Resource_Items/FPs20Inpt20Hosp20Care_En.pdf. Accessed 2012 Feb 23.

††Gutkin C. *Family physicians and hospitals*. [Vital Signs]. *Can Fam Physician* 1999;45:2548.

- *Other benefits include better support for patients and families coping with stressful and even life-threatening situations; more efficient use of system resources (eg, avoiding repetition of tests already performed); development of better overall care strategies that take into account the patient's past experiences and long-term goals; improved opportunities to decide on more appropriate specialist or special-service consultations; improved opportunities for physician self-improvement, and improved opportunity for transferring hospital-acquired skills and knowledge to the management of patients in community practices.*
- *Less obvious benefits but wellknown by older physicians are the elements that go to make up career satisfaction. These include the professional stimulation, camaraderie, and collegiality that come with frequent interaction with specialist colleagues. Strong intraprofessional relationships also have great value for patients needing specialty services in the community practice, since the referral process works more smoothly when it involves trust and familiarity.*
- *In this case, there is no ethically right answer. Clearly, good supporting values underlie most of the options mentioned earlier. However, the strongest, most persuasive values might be those underlying your most time-consuming choice as a family physician.*
- *As a discipline, family medicine continues to struggle with the practical implications that flow from fundamental disciplinary concepts, values, and principles, such as continuity of care and comprehensiveness.*
- *The case starts with information concerning Preston's visit to a walk-in clinic. Some decisions were made regarding changes in medication and some of these changes you find worrisome. Despite the ease with which you can electronically consult the provincial prescription database, correspond with pharmacists, and review notes from other medical clinics, none of these new modalities are meaningful substitutes for face-to-face clinical contact. Ways in which new technologies impact the patient-doctor relationship and particularly the unique relationship family physicians have with their patients merit careful consideration both before and after deployment.*

- *It would be useful to learn why Preston visited another clinic. A true understanding of patient-centred care involves a willingness to maintain open and honest communication, as well as a desire to remain sensitive to patient needs and preferences. You might learn, for instance, that Preston is among a growing number of patients in your practice who struggle with access to primary care, due in part to your clinic's location and hours of operation.*
- *The communication you received from the emergency room following Preston's admission to hospital is an example of misused technology interfering with quality patient care. An electronically distributed, scanned copy of mostly-illegible handwritten notes is a poor substitute for a quick phone call from either the emergency room physician or the admitting MRP. Sadly, this sort of communication rarely occurs in some settings.*
- *The cryptic message in your EMR concerning worries expressed by Preston's family members is a red flag deserving immediate attention. After obtaining Preston's permission, it would be good practice to meet with his niece and nephew as soon as possible to hear their concerns, provide whatever information you have regarding his cancer therapies, and to explain the usual timelines for both the disease and its treatment.*
- *After reviewing Preston's chart records and all the correspondence you have received from his surgeon and the cancer agency, you cannot see any obvious gaps in the expected follow-up process. In view of the fact his colon cancer was fairly extensive at the time of diagnosis, it is not entirely surprising that it has now recurred as metastatic disease. Additionally, a chest x-ray performed near the end of his chemotherapy treatments was clear, suggesting the recurrence is much more recent and still asymptomatic. Lung biopsies performed in hospital confirm the likelihood of metastatic disease rather than a new primary malignancy. A second meeting with Preston's relatives goes well. Although saddened with the news, they seem content with the explanations you have provided.*

- *If you had indeed found gaps or errors in follow-up, further consultation with your specialist colleagues might be warranted. While seeking to maintain neutrality in matters of “blame”, your role as family physician might well include the delicate provision of support and open communication if the family chooses to meet with your specialist colleagues. You might wish to seek advice from the CMPA if they approach you asking for support in pursuing legal avenues.*
- *Although all of the suggested action alternatives are supportable from an ethical perspective, the option of speaking in person with Preston’s MRP seems the most productive. The conversation may need to wait until Dr Davost returns from his conference and has had an opportunity to familiarize himself with Preston and his chart information. Alternatively, Dr Murray might be willing to meet with you immediately and together review the chart, correcting misinformation and clarifying the goals of therapy, especially now that important new information has come to light. This would present a good opportunity to ensure that Preston’s usual medications are reinstated, if appropriate.*
- *It would be very useful to review Preston’s advance directive with him and to make sure that its contents still represent his current wishes. After doing so, including it in his inpatient chart for future reference and noting its presence in an obvious fashion would also be important.*
- *Depending on the realities of your practice context, an offer to assume the MRP role could be made to Dr Davost. Preston would certainly be appreciative of your ongoing involvement. Your knowledge of his history combined with a complete understanding of his therapeutic goals might contribute significantly to wise stewardship of resources and quality, patient-centred care.*
- *Even if you do not take over as MRP, you can continue to help coordinate Preston’s care in terms of recommending appropriate in-hospital consultations (eg, palliative care, if that is the route Preston prefers, or oncology, if he prefers to remain more aggressive).*

You will also enable better post-discharge care if you remain well aware of the follow-up plans and the arrangements being made for improved supports in the home.

8. Review the outcomes

- a) Remind the residents that one of the luxuries of case discussions is that no real patients are harmed as a result of the decisions made.
- b) In real life, patients are sometimes harmed, as are families and other parties in the process of medical decision making.
- c) If a real (but de-identified) case was presented, ask the resident who presented it to tell his or her colleagues what really happened in the end. See how closely this resolution matches the preferred course of action as decided during the case discussion. Similarly, if the instructor presented the case, the ending can now be revealed:
 - *In the actual case, Preston's urosepsis quickly resolved on IV antibiotics. His mood remained good and he seemed to understand the situation completely. His family members provided strong support and daily visits. The chest x-ray findings were confirmed with CT examination and lung biopsies followed. Because Preston's strength had returned, he asked to be discharged and notified later about the biopsy results. You called him at home on a couple of occasions during the following week and then informed him that the biopsy results were indeed positive for metastatic cancer. Preston was disappointed but not really surprised. You referred him to the cancer agency and they offered him chemotherapy after seeing him approximately one month following hospital discharge. By that time, he was becoming a bit breathless and had begun to use home oxygen therapy. When told that the chemotherapy had a 25% chance of extending his life approximately six months, he called you to discuss his choice. You went to his apartment for this discussion and together decided that supportive palliative care was the better alternative. This decision was followed by your active participation with the palliative home care team until the time of Preston's death two months later.*

- d) While the preferred action alternative is often, and perhaps optimally, the one that remains the most consistent with the weightiest values and most persuasive principles and arguments, actual outcomes matter.
- e) Ask the residents to consider whether the actual outcome of the real case was, in retrospect, the best possible outcome, as viewed through the eyes of those involved. Was it accepted and valued by the patient, the MRP, and the family? Did it achieve mutually-agreed-on goals? Did it involve the least amount of sacrifice or compromise to values and principles?
- *In this case, Preston expressed his gratitude many times when you visited him at home. His niece and nephew were also very thankful. You were able to facilitate palliative coverage for all his medications and you coordinated follow-up with the palliative care team. Dr Davost recognized you immediately the next time you saw him in the hospital and asked about Preston's outcome. You have now begun to consult Dr Davost regarding difficult internal medicine cases. All in all, your participation in Preston's care has been personally satisfying and appreciated.*
- f) Emphasize that in real life, looking back at outcomes is crucial. It is not so much a matter of learning from one's mistakes as it is of developing an internal library of paradigm cases from which one can draw applicable and useful parallels in future case analysis. In other words, we can all get better at this and become more ethically mature through mindful, intentional reflection on the outcomes of troubling cases.

Further Reading

Articles and Reports

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(Pages 52–55 focus on family physician inpatient services)

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(Pages 12 to 15 are of particular relevance)

Sample Lesson Plan 5

A. Reproductive Choice and Nontraditional Families: Relevant CanMEDS Values and Themes

Values

- Patient-centred care
- Sensitivity
- Respectful interactions
- Trust
- Empathy
- Compassion

Themes

- The unique relationship family physicians have with their patients
- Respect for patient individuality and diversity
- Avoidance of unjust discrimination
- Advocacy for the health and well-being of communities and individual patients, and, in particular, vulnerable or marginalized patients and populations
- Protection of privacy and confidentiality

1. Introduce the topic

- a) Briefly present the following case. It can be electronically displayed or simply read aloud.

Case:

Gail is a 37 year old nulligravid woman for whom you have provided primary care services over the past 15 years. When her previous physician retired, she asked you to see her because her sister, Kari, was already one of your patients. Although their marriage ended in divorce three years ago, you also

serve as family physician for Gail's ex-husband, Garry, age 39. They were married about 14 years ago, so you have known Garry almost as long as you have known Gail.

Gail was diagnosed with Hodgkin's lymphoma nine years ago and treated with chemotherapy followed by radiation to the neck and chest. She recovered from this illness completely, but the treatments resulted in greatly diminished ovarian reserve, diagnosed during an infertility workup that resulted in three unsuccessful IVF/ICSI (in vitro fertilization/intracytoplasmic sperm injection) attempts, approximately six years ago. The couple was counseled about oocyte donation but decided against further intervention when Gail revealed her true sexual orientation to Garry. Although they dissolved their union amicably, you are aware that Garry still feels slightly embarrassed about pressuring Gail to have children with him while never realizing she was a lesbian. Gail has told you that for her part, she is sorry she didn't fully discuss the reasons for her reluctance to undergo fertility treatments with Garry, whom she still admires and respects.

Gail and her partner of 18 months, Corina, have approached you for counseling regarding their current procreative plans. Corina, age 40, is not one of your patients. Gail remarks that she has always wanted to have children, but was secretly relieved that her previous attempts with Garry had failed. She tells you that her sister Kari has offered to be an egg donor. Kari is three years younger than Gail. She is married and has three children, ages four, six, and nine. She uses an IUD for contraception and has decided, together with her husband Mike, that they will not be having any more children. Mike and Garry remain good friends, having first met a year or two prior to Gail and Garry's wedding, 14 years ago.

Gail and Corina tell you they have spoken with Mike, asking him to be the sperm donor. You actually learned this part of the story a week or two earlier, as Garry was in to see you and mentioned that Mike had told him about it. You don't tell Gail about having this information now, however. Gail plans to be her own gestational carrier and Corina seems okay with the plan, saying she is ready to begin a family. She remarks that she was originally a bit hesitant when Gail was considering asking Garry to be the sperm donor, but now that they've settled on Mike as the donor, she is comfortable to proceed. At this point, they would like to hear your views on the arrangements they've planned and

also ask you to refer them to the fertility clinic in your community. Gail says that she trusts you completely and hopes for your support during her pregnancy.

Gail, 37 – your patient, wishes to have a child

Corina, 40 – Gail’s female partner of 18 months

Garry, 39 – Gail’s ex-husband

Kari, 34 – Gail’s sister and potential oocyte donor

Mike, 35 – Kari’s husband and potential sperm donor

Gail’s marriage to Garry – 14 years ago

Lymphoma diagnosis and treatment – nine years ago

Fertility workup and treatment – six years ago

Gail’s divorce – three years ago

- b) Alternatively, present a case from your own experience, involving the unique and central role a family physician can play in counseling and supporting couples experiencing fertility concerns. Stop short of telling them “what happened” while presenting the case, reserving these details for the last step of the analysis process.
- c) After presenting the case, ask the residents to identify the main ethics topics that seem to arise within the case:
 - *Probably, the topics “same-sex parenting” or “reproductive choice” will be mentioned. “Non-discrimination” might also be identified. You might say, “I agree, this appears to be a complex case involving reproduction in nontraditional families. But what additional ethics issues are likely to arise for the people involved?”*
- d) The residents might suggest some of the following relevant issues. It would be useful to write them down or display them for future reference.
 - *A family physician’s role in providing continuity of care*
 - *Support for vulnerable or marginalized patients and populations*
 - *Complex extended family dynamics*
 - *First point of system contact for infertility concerns*
 - *Respect for autonomous choice*

- *Facilitation of appropriate specialty referrals*
 - *Complex issues of consent*
- e) If the list of identified issues is long, you might need to narrow the scope of the discussion by suggesting a few priority topics along the lines of the purposes stated immediately below.
- f) *The main purposes of today's case presentation are as follows:*
- *To highlight the family physician's role in counseling regarding infertility and reproduction*
 - *To understand the importance of nonjudgmental approaches when entering controversial moral territory*
 - *To emphasize the importance of advocacy in facilitating management of nontraditional health concerns*
 - *To heighten sensitivity to the complex interplay between family physician personal values and unusual or controversial health care needs*

Restate the topic:

- g) After outlining the case, you should clearly restate the purpose of the session by explicitly identifying the priority topics:
- *Emphasize that this sort of topic, while comparatively uncommon in its specifics, will almost certainly arise at some point within the normal context of group family medicine practice. Family physicians might feel inadequately prepared to deal with the science and process issues involved, but they also might struggle with the impact their personal views can have on this sort of clinical encounter and the continuing patient-doctor relationship.*
- h) You might wish to highlight the topic's relevance in the context of the ethics curriculum competencies (Appendix 1). You might also wish to reference the applicable values and themes as identified in the document *Mapping Ethics Values to CanMEDS-FM Roles* (Appendix 2), some of which the residents will have already

identified in step 1d). A list of relevant values and themes is provided to instructors at the beginning of this lesson plan.

- i) At this point, it is probably counterproductive to get into a discussion regarding solutions to the case, although many residents will have already formed their own opinions.
- j) It is often useful to quiz the residents about their initial ideas regarding the ethical tensions by asking, “What is the problem in this case?” Typically, they will state the problem in terms of alternative possible courses of action, or *action alternatives*. Action alternatives form a natural beginning point to many case discussions in ethics, even though they arise at a later point in formal case analysis. In this case, the most obvious action alternatives are as follows:
 - *The family physician could refuse to make the referral and refuse to discuss the infertility problem due to conflicting personal beliefs and matters of moral conscience.*
 - *The family physician could listen to this couple’s concerns but refuse to facilitate referral because of conflicting personal beliefs or matters of personal moral conscience.*
 - *The family physician could listen to this couple’s concerns but refuse to participate in the fertility workup and possible pregnancy due to personal moral conflict, while offering to transfer primary care temporarily to an agreeable family physician colleague.*
 - *The family physician could maintain strict neutrality by avoiding expression of either support for or opposition to the plan, while agreeing to refer the couple to an appropriate fertility clinic.*
 - *The family physician could counsel this couple with regard to the long-term implications of their procreative choices and facilitate referral to an appropriate fertility clinic.*
- k) If you choose to have the residents suggest a few other possible action alternatives at this time, you should encourage them to do so without detailing their supporting arguments. You can state that the values underlying or supporting each of these proposed alternatives will be identified more clearly later on, along with an attempt to weigh and balance their relevance, applicability, and importance.

2. Review the facts of the case

- a) After the case has been presented, ask the residents whether there are other facts they would find useful. You can offer to make up important missing facts if you anticipate that the case discussion will work better with this information available. Some suggestions are offered in part e):
 - If you used the case provided in this lesson plan, there might be questions that demand more detail than what is provided. It is reasonable to make up such details, provided you anticipate this will contribute to a better case discussion. The details you provide might include a composite set of circumstances from your own experience in such situations.
- b) A convenient and useful way to gather all the necessary facts is to organize them into groups using a bio-psycho-social format. This is not always necessary but it might help to avoid large gaps in data gathering.
- c) Emphasize that some facts such as medical prognosis and occasionally, diagnosis, cannot always be known with complete certainty, but that in real life, decision making must nevertheless proceed.
- d) In addition to biological facts, be sure to ask about psychological facts such as the patient's current state of mind and previously stated therapeutic goals. Also ask about social facts, which might include family context, religious and cultural factors, social support systems and relevant policies and laws.
- e) Facts that might prove useful for this particular case discussion might include the following:
 - *Biological*
 - *As women get older, the likelihood of a successful response to ovarian stimulation and progression to egg retrieval and embryo transfer decreases. The first two steps involve Kari's contribution and at age 34, the likelihood of success remains relatively stable but is already beginning to decline. At age 37, Gail's likelihood of experiencing successful embryo transfer is definitely less than it was earlier, but much greater than it would be if she were 40 or older.*

- *Corina initially wanted to be the egg donor, but the couple’s research suggested that Kari’s offer had a much higher likelihood of success and probably would reduce the financial expense associated with multiple IVF cycles. Corina is still ovulating, but the likelihood of successfully retrieving, fertilizing, and implanting one of her eggs is declining and will drop to 1% to 2% over the next couple of years. At age 34, Kari is still considered an ideal egg donor (younger than age 35, previous proven fertility).*
- *Egg donors are commonly screened with respect to medical history, physical exam, investigations (blood tests, genetic karyotyping, trans-vaginal ultrasound), full disclosure on an IVF cycle, and the potential risks of IVF, as well as psychological screening.*
- *Recipient couples are commonly screened with respect to infertility history, medical history (particularly elements that could potentially affect a pregnancy), lifestyle factors, physical exam, and investigations.*
- *Using suitable egg donors younger than age 35, typical Canadian success rates per IVF cycle are in the range of 50%. Therefore, under ideal circumstances, there is a one-in-two chance that at least two cycles will be necessary.*
- *The risk of chromosomal abnormalities in the fetus relates to the age of the egg donor, not the recipient. The likelihood of miscarriage in IVF is generally around 10% to 15%.*
- *Risks for Kari as an egg donor include medication side effects (bloating, mood changes, headaches, breast tenderness, low energy), ovarian hyper-stimulation syndrome (OHSS), infection, and bleeding.*
- *Risks for Gail as the egg recipient relate to potential medication side effects associated with preparing the uterine lining for implantation, as well as the potential risks associated with a multiple pregnancy (there is a 20% to 25% risk of twin pregnancy when three embryos are transferred). The recipient must also undergo a mock cycle before undergoing the actual embryo transfer.*

- *There is a slightly increased risk of low birth weight and premature delivery, and there may be an increased risk of birth defects in babies conceived through IVF/ICSI. Risk of ectopic pregnancy with IVF is 2% to 3%.*
- *Usually, one or two embryos are transferred into the recipient's prepared uterus three days after egg retrieval. A pregnancy test is performed two weeks later.*
- *Smoking reduces the chances of successful fertility treatment by up to 50%. Fortunately, none of the individuals involved in this case are smokers.*
- *Psychological*
 - *Psychological counseling is required for egg donors and embryo recipients before reproductive assistance is provided.*
 - *All involved individuals are encouraged to take the time to gain comfort with their decisions, with respect to ways in which their involvement might affect the child's life, the family's dynamics, and the place of each individual in their immediate and broader communities.*
 - *Partners of donors and recipients are also included in these sessions as practical and shared decisions must be made about what the child and other family members will be told.*
 - *A major goal of counseling is to achieve a broadly shared understanding amongst all participants, such that no one regrets his/her decision in the future.*
 - *In your view, Gail is psychologically healthy, intelligent, and has good coping skills. You met with her frequently during her battles with lymphoma and noted her strong personal resolve, optimistic nature, and general openness. You were somewhat chagrined to learn her true sexual orientation only six years ago, mostly because you thought that you previously knew her very well, yet this important information had never surfaced. Gail has assured you since that time that you were not alone in your ignorance; indeed most of her friends had no idea.*
 - *Although Gail and Corina have what appears to be a mature and stable relationship, it is of relatively short duration (18 months). This would likely be*

explored by the counselor, while recognizing that the biological timelines for all of the involved participants are such that extensive delay will significantly reduce the likelihood of success.

- Gail and Corina are financially secure, but do not have large cash reserves. Gail owns and operates a small consulting business engaged in fundraising activities on behalf of nongovernmental organizations (NGOs). Corina works as an accountant.*
- If successful pregnancy and delivery is achieved, the child will have the genetic potential of being closely similar to his or her first cousins and biologically, would be their sibling. At some later point, this might well be noticed both within the family and by others. Kari's and Mike's children, at ages four, six, and nine, are too young to understand such implications yet, but agreement concerning how this information will be conveyed in the future would be in everyone's best interests.*
- Garry's interests, while somewhat peripheral, cannot be ignored. From the case description, he is still a "family friend" insofar as his connection with Mike is ongoing. Moreover, his closeness to Gail is evident from her earlier inclination to ask him about sperm donation.*
- *Social*
 - In Canada, infertility has long been considered a medical condition warranting medical investigation and therapy, when appropriate. The 1993 Royal Commission on New Reproductive Technologies advanced this viewpoint, as have other national and international associations and medical organizations.*
 - In most Canadian jurisdictions, the fertility workup itself would be covered by provincial health care insurance plans. (In this case, some investigations, especially those involving Gail's fertility and donor suitability, might not be necessary because of known previous results.)*

- *In most Canadian jurisdictions, the medical correction of infertility is not covered by public health plans, although many fertility experts have argued in favour of such coverage.*
- *The cost for medications alone for one IVF cycle can range from \$2,000 to \$6,000 in Canada, and significantly more in the United States.*
- *The IVF/ICSI process will cost an additional \$6,500 per cycle, or thereabouts, and much more in the United States.*
- *In the case of surrogates or gestational carriers, there will likely be additional legal costs. (In this particular case, consideration would likely be given to a contract between Gail and Corina, insofar as Corina remains “genetically uninvolved.”)*
- *Egg donors and recipient couples must have a formalized legal contract that is independently reviewed by each of their respective lawyers and signed by all involved parties.*
- *Egg donors cannot be paid for their eggs in Canada, nor can they be paid for their time off work. Recipient couples can reimburse egg donors for receiptable expenses, such as medication costs, travel, childcare, etc.*
- *While same-sex couples can legally marry in Canada, not all legal implications for same-sex common-law couples, especially with respect to parental rights, have been fully clarified in law.*
- *In 2008, the Roman Catholic Church released a document called “Dignitas Personae: On Certain Bioethical Questions,” in which it confirmed its longstanding moral opposition to all artificial reproductive technologies (ARTs) including IVF and frozen embryo implantation, as well as gestational pregnancy and surrogacy.*
- *In the same document, pre-implantation genetic diagnosis was called “shameful and reprehensible,” and compared to the prescribing or use of contraception that prevents implantation, all of which lead to “the sin of abortion.”*

- Pope Benedict XVI has recently (February 2012) directed infertile couples to shun artificial procreation, calling such methods a form of arrogance.**
- Most modern rabbis agree that the biblical commandment to procreate implies tacit approval for assisted reproduction in Jewish law. However, controversy, if not outright opposition, remains with respect to egg and sperm donation among the more orthodox segments of the faith. At the same time, liberal clerics have been known to support IVF for lesbian mothers.
- Islam views infertility as a medical condition and artificial insemination (using the couple's own gametes) as morally acceptable. Since the late 1990's there has been a divergence of opinion regarding the practices of egg and sperm donation, previously viewed as immoral by all Muslims. Currently, many Shi'ite Muslims have adopted more liberal views than have Sunnis with respect to third-party gamete donation, although both forms of Islam continue to struggle with the impact these technologies have on traditional gender relations.
- ARTs are supported by both Hinduism and Buddhism, although the latter faith is more liberal in its blessing, with no access restrictions placed on unmarried couples and no prohibitions against gamete donation.
- Most protestant North American religions support assisted reproduction to greater or lesser degrees. Numerous moral controversies still exist, and notable gaps between official stance and popular practices are evident.
- Gail appears to be in a strong and supportive relationship. She also appears to have strong support and encouragement from her family. Her ex-husband's presence in the scenario does not seem to be a contentious issue or likely impediment. None of the participants is strongly religious.
- Social support for procreation within same-sex marriages is probably quite variable, depending on the size and location of the community, the presence or

**Clerical Whispers. [Blog] 2012 Feb 29. <http://clericalwhispers.blogspot.com/2012/02/pope-warns-against-arrogant-ivf.html> Accessed March 6, 2012.

absence of similar nontraditional families, and the availability of a network of like-minded friends and advocates. Predominant community characteristics such as ethnicity and religion might predict the availability of these social supports.

3. Review professional responsibilities

- a) Ask the residents to explain any professional responsibilities, policies, laws, or regulations that might apply to this case:
- *The CMA's Code of Ethics outlines some relevant professional responsibilities that apply to physicians, medical students, and residents:*
 - *“In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons.”*
 - *“Inform your patient when your personal morality would influence the recommendation or practice of any medical procedure that the patient wants or needs.”*
 - *“Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.”*
 - *ART policy is somewhat variable in Canada, affecting scope and accessibility of assisted reproductive technologies. There are more than 50 fertility clinics in Canada, the majority of them privately operated. While the initial investigation of infertility is an insured (ie, publicly funded) service in most provinces, subsequent assisted reproduction services are largely uninsured:*
 - *Most fertility clinics are commercial enterprises, free to set their own policies regarding patient selection, services offered, and fees, subject to any applicable provincial or federal laws and common ethical standards.*

- *Canadian law regarding assisted reproduction is currently in a state of flux (as of April 2012). The 2004 Assisted Human Reproduction Act was successfully challenged in the Supreme Court by Quebec, with support from New Brunswick, Saskatchewan, and Alberta. On December 22, 2010, the Supreme Court ruled, in a split decision, that provinces (but not federal authorities) have the right to regulate in vitro fertilization and some other forms of assisted human reproduction.*
 - *The Supreme Court decision allows provinces to regulate health aspects of fertility clinics, thereby reducing or nullifying the federal Act’s ability to regulate these activities nationally.*
 - *The absence of national standards has led some critics to suggest that “patchwork” regulations will result in reproductive tourism and greater potential danger for patients.*
 - *Portions of the Act were upheld by the Court, including the prohibition of for-profit egg and sperm donation, and for-profit surrogacy or gestational carrier service. Some other activities such as cloning and the use of human reproductive material in non-human life forms, chimeras, or hybrids in order to create human life, remain banned.*
 - *More practical and immediate questions, including guidelines for the number of embryos that should be implanted, standards for the collection of health information from sperm and egg donors, and the establishment of unified registries for tracking and research purposes are issues demanding speedy resolution.*
 - *No surrogacy contract has been tested yet in Canadian courts. When this happens, complex legal and ethical issues will undoubtedly arise. The Quebec Civil Code (1991) specifically prohibits surrogacy contracts, but other Canadian jurisdictions have no laws addressing surrogacy, nor is it clear whether contract law or family law would apply.*
- *As things currently stand, the request you have received from Gail and the plan she and Corina have outlined do not appear to contravene any applicable legislation.*

- b) Ask whether any of these standards conflict:
- *Obviously, selection and process standards will vary from clinic to clinic, but it seems unlikely that Gail and Corina will be refused consultation on the basis of any factors identified in the case description.*
 - *Some astute residents might suggest that there is a potential for serious conflict between portions of the CMA's Code of Ethics.*
 - *Some residents might point out that on the one hand, they are advised to avoid discrimination on illegitimate grounds and to provide any information requested by patients, while on the other hand, they are advised to tell patients when their personal beliefs will influence any medical recommendations or practices. It has been argued that being required to provide adequate information and counseling with respect to a procedure or treatment a physician deems unethical entails an unreasonable sacrifice of personal morality and professional autonomy. This view holds that family physicians facilitating such activities have similar moral culpability with respect to the outcomes, to those actually performing the therapies.*
 - *While such arguments are difficult to ignore, they are also difficult to resolve. They should be acknowledged as legitimate tensions in health care ethics while emphasizing aspects of professionalism that heavily influence adherence to the common standards of the profession or discipline.*
- c) If a particular standard appears to bear directly on one of the action alternatives mentioned in parts 1j) and 1k), draw this to the residents' attention, as some action alternatives might be automatically ruled out:
- *Each of the action alternatives mentioned in part 1j) might be influenced by the CMA's Code of Ethics, particularly the portions outlined in section 3 a). However, the first two action alternatives described are particularly problematic and even though not specifically prohibited, are inadvisable behaviours, for reasons explored below.*
- d) Provide the residents with directions to access necessary resources if they seem unaware of the case's relevant standards:

- *Information concerning reproductive technologies can be found by going to the resources provided at the end of this lesson plan.*
- *Ensure that the residents are aware of the current uncertain status of laws governing assisted reproduction in Canada.*

4. Identify relevant decision makers

- a) Ask for suggestions regarding the relevant decision makers:
 - *On the surface, this seems fairly simple. Gail is your patient and she is the one coming to you for advice and assistance. Nonetheless, her questions have profound implications with respect to her future health and well-being as a partner, mother, and family member. This recognition is consistent with family medicine's understanding of the contextual determinants of health.*
- b) While many decisions involve only the patient and the most responsible physician (MRP), other people often feel they have a say in the case. This is especially true of family members:
 - *Corina's involvement and support are important considerations. You have been told by both partners that it is their joint wish to proceed with assisted reproduction but any reinforcement of this belief gained through careful discussion would be reassuring.*
 - *From some perspectives, it would be inappropriate to focus on anyone's desires apart from those expressed by Gail. As with the issue of abortion, this view holds that decisions regarding Gail's body and its reproductive functions are hers and hers alone to make.*
 - *Kari and Mike have offered their assistance in addressing Gail's infertility and are therefore obviously included as relevant decision makers. We will assume that their participation will proceed on the basis of fully informed consent and that the fertility clinic is equipped to provide full disclosure.*

- c) Explore issues of competency, partial competency, dementia, immaturity, fear, depression, or other factors that might affect both the legitimacy and capability of the relevant decision makers:
- *There don't appear to be any concerns regarding the competency of any of the relevant decision makers.*
 - *It is important to recognize how powerfully emotions can influence decision making. In this case, Gail's family members might be strongly driven by complex feelings of compassion, altruism, familial solidarity, and allegiance to principles of fairness and justice. Gail's personal emotions might include longing, guilt concerning previous delay, fear regarding the possibility of cancer recurrence, and fear regarding the impact of advancing age. She might also be apprehensive about her role in bringing a child into a nontraditional family and fearful about the potential for negative reactions from friends and acquaintances.*
- d) Identify any possible conflicts of interest among the decision makers:
- *There are no obvious conflicts of interests in the identified participants. However, the potential future interests of the yet-to-be-created child are of obvious relevance. Reasonable assurance that Gail and Corina can provide a responsible, stable, loving and supportive home environment seem to be prerequisite conditions for ethical assistance with reproduction technologies. This is to say that science and medicine cannot claim value neutrality.*
- e) Identify the rights, roles, and responsibilities of surrogate decision makers if relevant:
- *There are no relevant proxies in this case.*
- f) While it is crucial to recognize family influences governing decision making, appropriate elements of confidentiality and informed consent must also be preserved:
- *The usual considerations regarding privacy and confidentiality, including protection of medical records, apply equally to your own actions and those to whom Gail is referred in consultation.*

5. Consider action alternatives

- a) Review any action alternatives already suggested:
 - See 1j) and 1k)
- b) On the basis of discussion to this point, ask the residents whether new action alternatives have become apparent.
- c) Rule out or modify action alternatives that directly conflict with therapeutic goals as voiced by competent patients or those that are illegal, impractical, against recognized policy, etc.
- d) Ask the residents to remain as open as possible to any available options, even those which might be viewed as “fringe,” non-medical, risky, unpopular, exotic, etc:
 - *Barring traditional folklore approaches to fertility concerns, there don't appear to be any reasonable options apart from Gail's requested referral. Because many fertility clinics are privately owned and operated, it should be acknowledged that self-referral is a legitimate option for many women. In some countries this is the norm, which raises the question of reproductive tourism, along with its attendant risks. There are also obvious issues surrounding access and fairness, given the substantial costs associated with ART services.*
- e) To avoid polarizing the debate, try to resist the temptation to ask the residents to name the “right” or “ethical” alternative.

6. Identify values and principles supporting various alternatives

- a) Ask the residents to outline some of the values and principles they have in mind when they reflect on each action alternative.
- b) It sometimes helps to write down these values beside the proposed action alternatives. For example:
 - *The option of refusing to discuss the infertility problem with Gail and also refusing to make the referral because of conflicting personal beliefs might be supported by the following values:*
 - *Maintaining personal and professional autonomy*

- *Protecting the freedom to act in accordance with one’s conscience or on the basis of religious or moral beliefs*
- *Respect for one’s own religious community and adherence to that community’s standards*
- *The option of listening to the couple’s concerns but refusing to facilitate referral because of conflicting personal beliefs or matters of personal moral conscience might be supported by the following values:*
 - *All of the values mentioned for the preceding option*
 - *The additional values of patient-centred care and respectful interactions, although listening alone, in the absence of any intention to act, is a poor example of these values, and might also be viewed as deceitful or purposefully misleading*
- *The option of listening to the couple’s concerns and then temporarily transferring their care to a family physician colleague because of your own moral opposition to the referral, might be supported by the following values:*
 - *All of the values mentioned in the first option, above*
 - *Increasingly patient-centred values and values of respect, insofar as facilitation of the couple’s legitimate desire is more likely to ensue*
 - *This alternative seems less discriminatory than the previous two and therefore has more visible elements of fairness, if not genuine empathy*
- *The option of maintaining strict (moral) neutrality by avoiding expression of either support for or opposition to the plan, while agreeing to refer the couple to an appropriate fertility clinic might be supported by the following values:*
 - *Respects the couple’s desire for referral without delay, thereby avoiding unjust discrimination*
 - *Promotes advocacy for members of a vulnerable and sometimes marginalized community*
 - *Respects patient individuality and diversity*

- *Promotes a degree of professional and personal autonomy if the reason for maintaining neutrality is grounded in personal (private) moral opposition to the plan*
 - *The option of counseling the couple with regard to the long-term implications of their procreative choices and facilitating referral to an appropriate fertility clinic might be supported by the following values:*
 - *In addition to some of the values supporting the preceding option, this alternative demonstrates genuine patient-centredness, compassion, and empathy*
 - *The values underlying the theme of family physicians establishing unique relationships with their patients support this option*
 - *Note that the negative values (ie, the values that might underlie opposition to any of the preceding action alternatives) have not been laid out in the same fashion as the supporting values. While this has been done for purposes of time efficiency, it would be important to discuss those reasons during the next stage of case analysis.*
- c) At this stage, try not to rank these values and principles. Instead, just recognize openly that most realistic courses of action are supported by legitimate and often deeply held values. This point will emphasize that ethics issues are controversial for exactly that reason; they bring values into conflict or competition.

7. Weigh and balance various alternatives

- a) Ask the residents to develop arguments in support of one or more particular course of action, as opposed to the other alternatives. Small-group discussions can be useful at this stage:
- *It may be more time efficient to separate into groups of five or six residents, each group attempting its own resolution of the case after hearing the ideas previously expressed during the large-group discussion.*
- b) Remind the residents to apply their knowledge of ethical concepts and themes in family medicine, as well as the values they have identified underlying the action alternatives.

- c) When weighing and balancing various alternatives and their supporting values, suggest to the residents that there is no mathematical calculus—more often than not, the balance is not heavily weighted in one direction.
- d) Residents might suggest that there is no right answer in ethics. Try to resist this relativity trap. Your response might include some of the following suggestions:
- *In fact, there are often several right answers, insofar as several alternative courses of action can have strong ethical justification.*
 - *In ethical dilemmas, we are usually looking for the best possible solution rather than the only right solution.*
 - *Sometimes there are no good choices, but one still needs to choose. This is often referred to as the “lesser of many evils” scenario.*
 - *Sometimes, choosing to defer, to step back, or to temporize is the best possible course of action.*
- e) Recognize the possibility of not coming up with a unanimously accepted solution. This happens relatively frequently—not everyone agrees at the end of the discussion, but all should agree that the reasons supporting the chosen course of action are valid, understandable, and fair.
- f) Occasionally, the discussion will get stuck or will stall. This presents an opportunity to ask the residents what they would do next if such a situation were to arise in real life. Options would include consultation with an ethicist or ethics committee, conversation with other colleagues, review of the relevant literature, etc. Keep in mind that many ethics decisions in medicine are not urgent. Reflection takes time:
- *As shown above, the first three options in 6 b) are not without supporting values, even though the options themselves are problematic for many reasons. Physicians who have adopted one of these stances have done so on the basis of conscientious objection, a topic that has garnered significant media attention and generated an extensive literature.*
 - *It has been argued by some theologians and ethicists that facilitation of an act to which one is morally opposed (and which one views as “evil” or morally abhorrent) is the moral equivalent of personally participating in that act.*

- *In 2008, the Ontario Medical Association successfully lobbied the College of Physicians and Surgeons of Ontario to abandon its draft policy, in which physicians who prioritized their personal religious views over the wishes of their patients would be charged with professional misconduct.*
- *Even if provincial medical regulatory bodies choose to exclude such practices from their definitions of unprofessional conduct, physicians who prioritize issues of personal conscience might nonetheless face charges filed through provincial Human Rights Commissions.*
- *The 30th anniversary of the Canadian Charter of Rights and Freedoms (April 17, 2012) brings with it some interesting questions regarding the societal impact of an increasing emphasis on individual rights. This emphasis has perhaps contributed to commonly heard assumptions among a particular generation of physicians regarding their right to exercise personal autonomy in the practice of their profession. Similarly, the Charter may have contributed to the production of a generation of Canadians claiming individual rights of access to an increasingly broad menu of health care services. In both instances, previously dominant Canadian values such as compromise, sharing, community solidarity, and accommodation no longer have the same overarching influence on policy, practice, and personal behaviour.*
- *Patient-centred care is central to the discipline of family medicine and along with continuity of care, lays the foundation for the unique relationship family physicians have with their patients.*
- *Sensitivity to patients' expressed concerns can only occur in relationships that are trusting and mutually respectful. Physicians can demonstrate compassion through empathetic listening, but trust is established by following through with actions marked by advocacy and nondiscrimination.*
- *If you choose to avoid listening to Gail's concerns, thereby prioritizing your own moral and/or religious views instead, you run the risk of sacrificing any previous trust that has been established in the long-term therapeutic relationship you have with her.*

- *If you choose to hear her concerns but subsequently refuse to refer, you will likely be seen to pass judgment on Gail's personal reproductive choice. You might also be viewed as exercising inappropriate gatekeeper authority through paternalistic posturing.*
- *Transferring primary care (and referral responsibility) temporarily to another family physician, if openly and honestly discussed, might be viewed by Gail as an acceptable exercise of your own personal autonomy. However, it might also be viewed as a self-serving avoidance maneuver, or even worse, as abandonment. Additionally, it has the potential disadvantage of delaying initiation of any assisted reproduction treatments, and as discussed earlier, the individuals involved in this case are approaching their "best before" dates.*
- *Maintaining strict neutrality by avoiding expression of either support for or opposition to Gail's plan has the advantage of early referral facilitation, along with the appearance of support, advocacy, and nondiscrimination. However, an important opportunity to contribute to meaningful long-term planning is missed, thereby diminishing the unique and valuable role a family physician can play in a continuing care relationship.*
- *The last action alternative, as outlined in part 1j) has several advantages. It demonstrates genuine patient-centred care through sensitive, respectful interaction, while generating trust in the compassionate and supportive environment characterizing strong family medicine relationships.*
- *As Gail's longtime physician, it would be important to raise points of uncertainty regarding future plans and how they might impact physical, emotional, and spiritual well-being. The following issues are possible discussion points:*
 - *How will Gail and Corina be affected if their reproductive attempts do not succeed?*
 - *How will the significant financial expenses involved affect their future ability to provide a supportive home environment for their son or daughter?*

- *Is the one-in-four chance of a twin pregnancy (with 3-embryo transfer), along with its risks and long-term implications fully understood by Gail and Corina? (Note: multiple-embryo transfers have recently become less commonly utilized.)*
- *Have they formulated their explanations for curious friends, coworkers, neighbours and acquaintances?*
- *Are they worried about any of the legalities surrounding parental rights issues or rights of egg and sperm donors? Have they obtained solid legal advice in this regard?*
- *Do they intend to explain to their son or daughter the origins of his or her genetic material? If so, how will they know when it is the right time?*
- *Have they considered the future impact, if any, that having a son or daughter with very similar genetic makeup to his or her cousins might have on interfamilial relationships?*
- *Is Gail fully aware of the risks associated with pregnancy and is she accepting of those risks? How does being a cancer survivor affect her reproductive decisions?*
- *All of these questions and many more will be further explored by the psychologist associated with the fertility clinic. These individuals have specific expertise in assessing the psychological and emotional readiness of applicants for reproductive assistance.*

8. Review the outcomes

- a) Remind the residents that one of the luxuries of case discussions is that no real patients are harmed as a result of the decisions made.
- b) In real life, patients are sometimes harmed, as are families and other parties to the process of medical decision making.
- c) If a real (but de-identified) case was presented, ask the resident who presented it to tell his or her colleagues what really happened in the end. See how closely this resolution matches the preferred course of action as decided during the case discussion. Similarly, if the instructor presented the case, the ending can now be revealed.

- d) While the preferred action alternative is often, and perhaps optimally, the one that remains the most consistent with the weightiest values and most persuasive principles and arguments, there is little doubt that actual outcomes do matter.
- e) Ask the residents to consider whether the actual outcome of the real case was, in retrospect, the best possible outcome, as viewed through the eyes of those involved. Was it accepted and valued by the patient, the MRP, and the family? Did it achieve mutually-agreed-on goals? Did it involve the least harm to sacrificed values and principles? Did it do the least harm to any other people involved in the case? Would the participants make the same decision again in similar circumstances?
- *The case presented in this lesson plan is a composite case and several of the details have been changed. Therefore, actual outcomes cannot be revealed at this time.*
 - *Although the case involves a same-sex couple and nontraditional reproductive choice, the challenges some family physicians will experience with respect to conscientious objection extend to other aspects of family practice.*
 - *A commitment to the patient's well-being demands a personal recognition of instances in which one's personal morality might hinder that commitment. Edmund Pellegrino and David Thomasma have argued in their book *The Virtues in Medicine* that resolving the conflict between principles and individual interpretation of how those principles ought to be applied can be extremely difficult, but that justice has a "trumping function" in these conflicts:*
 - "When the patient or social policy dictates that the physician submerge her own moral values to accommodate the patient's demands, even if what is demanded is accepted practice, then the conflict is between the patient's and the physician's autonomy. Hence, we must argue that the physician, no less than the patient, is a moral agent, that her autonomy is as deserving of respect as the patient's, and that justice would require that neither the physician nor patient impose her values on the other. If it is maleficent to violate the autonomy of the patient, it is equally maleficent to violate that of the physician."

“In practical terms, this will mean that, institutionally and ethically, mechanisms must be devised to permit physicians as well as patients to withdraw from their relationship. This must be done amicably, respectfully, and only after another physician has agreed to accept the transfer of responsibility for the care of the patient. The physician cannot withdraw without first making provisions for transfer to another physician because to do so would constitute abandonment, in itself a serious breach of ethical obligation rooted in the virtue of justice and the principle of beneficence.”^{§§}

- *In effect, Pellegrino argues that the virtuous physician will not only recognize when moral conflict arises, but will act consistently with his or her morals by withdrawing from such relationships only after ensuring his or her professional duties have first been discharged. The difficulty with this view is that while it partially succeeds in terms of mutual respect, advocacy, and patient-centredness, it generates serious tensions between physicians’ personal rights and adherence to the standards of the profession.*
- f) Emphasize that in real life, looking back at outcomes is crucial. It is not so much a matter of learning from one’s mistakes as it is of developing an internal library of paradigm cases from which one can draw applicable and useful parallels in future case analysis. In other words, we can all get better at this and become more ethically “mature” through mindful, intentional reflection on the outcomes of troubling cases.

^{§§}Pellegrino E, Thomasma D. *The Virtues in Medicine*. New York, NY: Oxford University Press; 1993.

Further Reading

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Resources

<http://www.usask.ca/medicine/obgyn/artus/index.html>

(see information sheets, in particular)

www.infertilitynetwork.org

www.fertility.com

www.myfertility.ca

www.obgynworld.co

www.serono-canada.com

www.iaac.ca

(Infertility Awareness Association)

www.organon.ca

(Patient Education)

www.ivfconnections.com

Tips for Integrating Ethics in Clinic

Instructors will note that the CE-CFPC ethics competencies are observable and to some extent, measurable resident characteristics. Many of the competencies describe skills, knowledge, attitudes, and behaviours that residents will display as they go about their daily clinical practices. There is a tendency for residents (and often, faculty) to fail to recognize that most clinical cases involve at least some common ethics themes, values, or issues. Formal teaching sessions in ethics will become more relevant and useful if faculty members draw attention to ethics in the course of daily practice.

Faculty can promote the understanding and importance of ethics in family medicine by using some of the following suggested tips:

- In reviewing cases with residents, ask them to specifically identify any ethics issues that have arisen.
- Quiz residents about their knowledge of applicable values and principles of ethics.
- Ask residents to explain their clinical application of professional standards, rules, policies, and laws applicable to ethics.
- When discussing awkward clinical encounters, discuss and assess the resident's understanding of the need to be aware of and respectful toward cultural, ethnic, and religious diversity.
- When discussing investigations, tests and therapeutics, ask residents whether they have considered costs; availability; access; and possible benefits, risks, and burdens to the patient for each option.
- During sign-in and sign-out rounds, ask residents to include in their reports any questions they had about competing values that might have affected their medical decision making.
- Prior to resident-provided clinical teaching sessions (often, case presentations followed by topic review), ask residents to include relevant ethical considerations in their presentation and discussion.

Appendix 1: Competencies in Ethics and Professionalism for Canadian Family Medicine Residency Programs

Curricula on ethics in Canadian family practice residency programs should relate residents' education in ethics to issues that arise specifically in family medicine. Graduates of a Canadian family medicine residency program should achieve the four competencies outlined below. Each competency is described in some detail and for some descriptors, examples are provided. *These bulleted lists are not intended to prescribe curriculum content, but are provided as examples only.*

A. Identify, Explain, and Apply Ethical Values and Principles Relevant to Family Medicine

1. Residents will be able to identify, explain, and demonstrate in their clinical attitudes and behaviours, the unwavering commitment to patients that lies at the heart of family medicine.
2. Residents will be able to describe and apply key ethical values and principles in patient and family-focused care and discuss with their preceptors which particular values and principles are at stake in specific clinical cases. Examples of key ethical values and principles include the following:
 - Trust as the basis of a good doctor-patient relationship
 - Respect for the patient's role in decision making (autonomy)
 - Privacy and confidentiality
 - Effacement of physician self-interest
 - Benevolence
 - Compassion
 - Honesty
 - Justice
 - Accountability
 - Prudence and stewardship
 - Consequences, duties, and obligations

3. Residents will be able to integrate the ethical values and principles of patients, family members, and other care providers into patient care by soliciting the views of these individuals attentively and respectfully. Residents will demonstrate that they are able to communicate with patients and family members in a manner that is caring, empathetic, and attuned to cultural, ethnic, and gender diversities.
4. Residents will be able to identify, explain, and apply key ethical values and principles relating to other areas of family medicine such as practice management and relationships with third parties. Residents will be able to discuss particular values and principles at stake in these various relationships. Examples of common relationships include those with the following parties:
 - Pharmaceutical companies
 - Insurance agencies
 - Government and community service agencies
 - Colleagues and professionals in other disciplines
 - Health system resource allocators
 - Researchers
5. Residents will be able to describe how various values and principles can sometimes be in tension or conflict, both for family physicians and for their patients, and to manage these tensions and conflicts appropriately. For example:
 - Respecting a patient's autonomy could conflict with benevolence (eg, preventing harm)
 - Promoting trust in the physician-patient relationship and maintaining patient confidentiality could conflict with honesty and accountability
 - Benevolence in caring for individual patients could conflict with stewardship and justice (eg, failure to fulfill obligations to other patients)
6. Residents will be able to describe the importance of ethical concepts relevant to family medicine and apply them appropriately. Examples of ethical concepts central to family medicine include the following:
 - Patient- and family-focused care
 - Fiduciary relationships
 - Proportionality of interventional benefits to burdens

B. Define and Elaborate Ethical Responsibilities Pertaining to Professional and Legal Standards in Family Medicine

1. Residents will be able to access and outline professional responsibilities, standards, and policies that have a bearing on ethics in family medicine. Examples of applicable standards and policies include the following:
 - Codes of Ethics
 - Canadian and provincial College of Physicians and Surgeons policies and bylaws
 - Licensing requirements
 - Local institutional policies

2. Residents will be able to outline and describe how to find provincial and federal laws and regulations relevant to family medicine. Examples of relevant laws and regulations include those addressing the following:
 - Confidentiality and privacy
 - Consent to health care
 - Substitute decision making and advance directives
 - Involuntary admission to mental health facilities
 - Decision making regarding minors
 - Human rights and disability rights legislation
 - Communicable diseases
 - Abuse and neglect
 - Family law

3. Residents will be able to outline the roles and responsibilities of family physicians, patients, family members, other care providers and consultants pertaining to professional and legal standards. They will be able to initiate and facilitate discussions with patients and preceptors pertaining to their ethical responsibilities relevant to these standards.

C. Demonstrate Ethical Reasoning

1. Residents will be able to demonstrate that they have taken into account the following components, if relevant, when analyzing specific cases:
 - Clinical facts and probabilities

- Professional, legal, and ethical responsibilities
 - Ethical values and principles
 - Other applicable concepts in ethics
 - Approaches to ethical decision making
 - Views of the relevant stakeholders (eg, patient, family, other health care professionals, administrators)
2. Residents will be able to discuss and assess alternative courses of action, provide morally defensible reasons for decisions and actions with reference to the considerations named in C1, and apply their ethical reasoning.

D. Manage Ethical Disagreements and Seek Help Appropriately

1. Residents will demonstrate in their clinical interactions that they are able to identify and respectfully discuss and manage value differences and conflicts that arise in patient care and in working with others.
2. Residents will demonstrate an ability and willingness to seek clarification or advice in clinical situations involving complex ethical or legal dimensions, or uncertainty regarding applicable ethical, policy, or legal norms.

Appendix 2: Mapping Ethical Values to CanMEDS-FM Roles

A. CanMEDS-FM Ethics Excerpts

The following *italicized* excerpts identify ethics themes embedded in the CanMEDS-FM role descriptions, available from <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>.

The first excerpt, **in boldface**, identifies what we take to be the primary ethical obligation for all Canadian family physicians.

It might be said that the entire CanMEDS-FM document is based on an idealized conception of the “good family physician” and therefore, the “ethical family physician.” An attempt is made here to distill the most explicitly referenced ethics themes and values contained in the document. One-to-one mapping (ie, values-to-roles) will not be attempted and is probably not necessary as ethical values are seen to be overarching, governing, and guiding behaviour for each of the roles, even when they are not explicitly mentioned.

1. Family medicine expert

General

Family physicians **apply and integrate medical knowledge, clinical skills** and *professional attitudes* in their provision of care.

- Family physicians’ unique expertise is intimately tied to their *relationships* with their patients, for whom they are often the primary and continuing contact for health care.
- They use the *patient-centred clinical method* in assessing and managing clinical problems, which involves *partnering with patients and families* in health and illness.
- Family physicians *communicate and collaborate effectively* with patients; families; communities; and other health care professionals, including teams of providers.
- They serve as coordinators of care and *demonstrate a long-term commitment* to their patients.

Specific

- Consider issues of *patient safety and ethical dimensions* in the provision of care and other professional responsibilities.
- Apply acquired knowledge, skills, and *attitudes* to daily clinical practice.
- *Consciously enhance the patient-physician relationship* recognizing characteristics of a therapeutic and *caring relationship*.
- Utilize diagnostic and therapeutic interventions meeting the needs of the patient according to available evidence, *balancing risks, benefits, and costs*.
- *Recognize and respond to the ethical dimensions in clinical decision making*.
- Demonstrate timely performance of relevant diagnostic and therapeutic procedures, including *obtaining informed consent*.
- Appropriately incorporate families and other caregivers in the care of patients, while *abiding by the ethical standards of patient autonomy and consent*.

2. Communicator

General

- As communicators, *family physicians facilitate the doctor-patient relationship* and the dynamic exchanges that occur before, during, and after the medical encounter.
- Family physicians *integrate a sensitive, skillful, and appropriate search* for disease and illness.
- Family physicians have an *understanding and appreciation of the human condition, especially the nature of suffering* and patients' response to illness.
- They are skilled at providing information to patients in a manner that *respects their autonomy* and empowers them.
- Family physicians are able to establish and maintain *effective communication in the face of patients' disabilities, cultural differences, and age group differences*, as well as in challenging situations.
- The competencies of this role are essential for *establishing rapport and trust*.

Specific

- Establish positive therapeutic relationships with patients and their families that are characterized by *understanding, trust, respect, honesty, and empathy*.
- *Respect patient confidentiality, privacy, and autonomy.*
- *Respect boundaries* in the doctor-patient relationship.
- *Deliver information* to a patient and family, colleagues, and other professionals *in a humane manner.*
- *Disclose errors or adverse events* in an effective manner.
- *Respect diversity and difference*, including but not limited to the impact of gender, religion, and cultural beliefs on decision making.
- Communicate appropriately using electronic mail and other electronic means, while *maintaining patient confidentiality.*

3. Collaborator

Specific

- Recognize and *respect the diversity of roles, responsibilities, and competencies* of other professionals in relation to their own.
- *Respect team ethics, including confidentiality, resource allocation, and professionalism.*
- *Demonstrate a respectful attitude* toward other colleagues and members of an interprofessional team.
- *Respect differences, misunderstandings, and limitations* in other professionals.

4. Manager

General

- *Family physicians use resources wisely* and organize practices that are a resource to their patient population to sustain and improve health, coordinating care with the other members of the health care system.
- Family physicians engage in *continuous quality improvement* within their own practice environment.

Specific

- Recognize the importance of appropriate *allocation of healthcare resources*.
- *Judiciously manage access* to scarce community resources and referral sources.
- *Contribute to policy development* related to systems of health care.
- *Participate in relevant administrative roles* related to clinical care.

5. Health Advocate

General

- Family physicians *recognize their duty* and ability to improve the overall health of their *patients and the society* they serve.

Specific

- *Identify vulnerable or marginalized populations* and respond as needed.
- *Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity, and idealism.*

6. Scholar

General

- Family physicians adopt a *critical and evidence-informed approach to practice* and maintain this approach through continued learning and *quality improvement*.

Specific

- Describe the principles of ethics with respect to teaching.
- Describe the principles of research ethics.

7. Professional

General

- As professionals, family physicians are committed to the health and well-being of individuals and society through *ethical practice*, profession-led regulation, and *high personal standards of behaviour*.
- The professional role is guided by *codes of ethics* and a commitment to clinical competence, *appropriate attitudes and behaviours, integrity, altruism, personal well-being, and the public good*.
- These commitments form the basis of a *social contract* between a physician and society. Society, in return, grants physicians the privilege of profession-led regulation with the understanding that they are *accountable* to those served.

Specific

- Exhibit *professional behaviours* in practice, including *honesty, integrity, reliability, compassion, respect, altruism*, and commitment to patient well-being.
- Recognize and appropriately *respond to ethical issues* encountered in practice.
- *Demonstrate respect* for colleagues and team members.
- *Appropriately manage conflicts of interest*.
- Recognize the principles and limits of *patient confidentiality* as defined by professional practice standards and the law.
- Maintain appropriate *professional boundaries*.
- *Speak directly and respectfully* to colleagues whose behaviour could put patients or others at risk.
- *Appreciate the professional, legal, and ethical codes of practice*, including knowledge of the CMA Code of Ethics.

- *Demonstrate accountability* to professional regulatory bodies.
- Recognize and *respond to other professionals in need*.
- Demonstrate an awareness of self, and an understanding of how one's *attitudes and feelings* impact one's practice.

8. CanMEDS-FM ethics values and themes: Summary

In this summary, the values that are either implicitly or explicitly referenced in CanMEDS-FM have been identified. Many of them are repetitively stated or alternatively, bridge a number of the CanMEDS roles. Major topics or themes in ethics have also been identified. These themes can be viewed as areas of focus within an ethics curriculum, including possible topics for lectures, small-group sessions, or case-based discussion categories.

It is important to note that the values and themes highlighted above and summarized below can also be used to integrate ethics education into existing clinical curricular design. Specific reference can be made to these items when developing curricular content and evaluation criteria.

An initial overarching theme, perhaps better regarded as a physician's "primary ethical duty," is stated in the general description of the family medicine expert role: "Family physicians apply and integrate medical knowledge, clinical skills and professional attitudes in their provision of care." ****This CanMEDS-FM statement clearly identifies the prerequisite need for professionally applied clinical competence. The more nuanced descriptors for each CanMEDS-FM role can be viewed as components of the archetype (ie, a clinically skilled family physician with the right attitude).

General values, such as those listed below, can also be viewed as characteristics or traits of the model family physician. In some theoretical orientations within ethics, these character traits are common descriptors of the virtuous physician.

Values

***Working Group on Curriculum Review. CanMEDS–family medicine. Mississauga, ON: College of Family Physicians of Canada; 2009. Available from: <http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf>. Accessed 2012 Aug 17.

- Patient-centred care
- Continuity of care
- Caring relationships
- Sensitivity
- Respectful interactions
- Collaboration and partnering
- Good communication
- Long-term commitment to patients
- Patient safety
- Trust
- Empathy
- Altruism
- Integrity
- Idealism
- Accountability
- Honesty
- Compassion
- Reliability

Themes

- The need for clinical competence
- The need for professional attitudes
- The unique relationship family physicians have with their patients
- The ethics of team participation
- The ethics of patient safety and medical error
- Respect for patient individuality and diversity
- Avoidance of unjust discrimination
- Wise use of scarce health care resources
- The need to contribute to system improvement
- The need for self-improvement
- Advocacy for the health and well-being of communities and individual patients, and in particular, vulnerable or marginalized patients and populations
- Implications of the social contract
- Principles of ethics in research
- Recognition and management of conflicts of interest
- Protection of privacy and confidentiality

- Maintenance of professional boundaries
- Responsibilities to the profession
- Responsibilities to colleagues in difficulty
- Professional and personal conduct